Supreme Court, U. S.
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In the Supreme Court of the United States

No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, FRANK BEAL; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

JURISDICTIONAL STATEMENT

NORMAN J. WATKINS
Deputy Attorney General
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CITATION TO OPINIONS BELOW

The District Court's original decision in this case is reported at 402 F. Supp. 1039. On appeal, this Court vacated that opinion and remanded the case for further consideration *sub nom Kremens v. Bartley*, 431 U.S. 119 (1976). On remand, the lower court's decision and order, which are yet unreported, were issued on May 25, 1978 (Page 50a and page 84a).

STATEMENT OF JURISDICTION

This Court has jurisdiction over this appeal pursuant to 28 U.S.C. § 1253 in that this appeal is taken from an order granting a permanent injunction in a civil action required to be tried by a district court of three judges.* The final decision and order of the District Court were entered on May 25, 1978. This appeal was taken on May 26, 1978.

*This action was commenced on November 16, 1973, prior to the passage of P.L. 94-381 which significantly altered the requirements for convening a three-judge court.

CONSTITUTIONAL PROVISIONS INVOLVED

Fourteenth Amendment to the Constitution of the United States, in pertinent part:

> "Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

STATUTORY PROVISIONS INVOLVED

The Pennsylvania Mental Health and Mental Retardation Act of 1966, section 402 (Act of Oct. 20, 1966, Special Sess. No. 3, P.L. 96, art. IV, §402) is set forth as follows:

"(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application for admission has been made under the provisions of section 402(a) (2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of section 402(a) (2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

(d) Each admission under the provisions of this section, shall be reviewed at least annually by a committee, appointed by the director from the professional staff of the facility wherein the person is admitted, to determine whether continued care is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and

such other persons as the secretary by regulation may permit.

Where the admission is under the provisions of 402(a) (2), the person admitted shall be informed at least each sixty days of the voluntary nature of his status at the facility."

The Pennsylvania Mental Health and Mental Retardation Act of 1966, section 403 (Act of Oct. 20, 1966, Special Sess. No. 3, P.L. 96, art. IV, §403) is set forth as follows:

"(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the directors of his intention or desire to leave the facility, or after the applicant or his successor has given notice of intention or desire to remove the detained person.

(d) Each commitment under the provisions of this section shall be reviewed at least annually by a committee, appointed by the director from the

professional staff of the facility wherein the person is cared for, to determine whether continued care and commitment is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation shall permit.

Where the commitment is under the provisions of section 403(a) (2), the person committed shall be informed at least each sixty days of the voluntary nature of his status at the facility.

The Mental Health Procedures Act, sections 201, 205 and 206 (Act of July 9, 1976, 160th Regular Sess., P.L. 143, art. II § 201, 205, and 206 are set forth as follows:

Section 201. Persons Who May Authorize Voluntary Treatment.

Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

Section 205. Physical Examination and Formulation of Individualized Treatment Plan.

Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment

plan shall be formulated by a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

Section 206. Withdrawal from Voluntary Inpatient Treatment.

(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203, he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may affect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed

to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or his designate.

QUESTIONS PRESENTED

I. Did The Lower Court Err By Concluding That Both The 1966 And 1976 Acts Violate The Due Process Clause Of The Fourteenth Amendment With Respect To The Admission Of Children To Mental Health Facilities?

II. Did The Lower Court Err In Placing The Plaintiffs And Defendants In Single Classes?

III. Are The Retroactive Aspects Of The Injunctive Relief Granted By The Lower Court Improper?

STATEMENT OF THE CASE

On November 16, 1972, the plaintiffs, juveniles under the age eighteen, instituted this action challenging the constitutionality of several Pennsylvania statutes which allowed parents to voluntarily obtain medically necessary inpatient mental health and retardation services for their children.[1] The thrust of their complaint was that the statutory and regulatory procedures for the admission of children to mental health and retardation facilities violated the Due Process requirements of the Constitution because they did not require prior notice and hearing at which the child could contest this parental decision. After a trial on the merits of these claims, the District Court ruled in favor of the plaintiffs and enjoined the enforcement of those statutes. *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975).

An appeal was taken to this Court. However, while that appeal was pending the Pennsylvania Legislature enacted the Mental Health Procedures Act[2] which repealed the challenged statutes only insofar as they applied to mentally ill children. After oral argument this Court vacated the District Court's opinion and remanded the case for further consideration in light of the changed circumstances occasioned by this new legislation. *Kremens v. Bartley*, 431 U.S. 119 (1976).

On remand the plaintiffs amended and supplemented their complaint adding representative plaintiffs, and a

[1]The plaintiffs were specifically challenging the voluntary admission procedures contained in the Mental Health and Mental Retardation Act of 1966, 50 Pa. Stat. Ann. § 402 (a) (2); § 402(c); and § 403(a) (2). These statutes are set forth in the appendix to this Jurisdictional Statement and will be referred to as the "1966 Act." (a-).

[2]50 Pa. Stat. Ann. § 7101 et seq. (hereafter referred to as the "1976 Act").

class of defendants[3] However, they did not alter the theory of their claim, premising their challenge to both the 1966 and 1976 Acts on the Due Process Clause of the Fourteenth Amendment.

On May 25, 1978, the District Court entered its decision and final order once again declaring the challenged statutes unconstitutional, and enjoining their enforcement. Specifically, the Court ordered that every child admitted by his parents to a mental health facility, whether public or private, be provided two separate adversary hearings commencing no later than three days after the admission. The first hearing is for the purpose of determining the existence of ". . .probable cause to believe institutionalization is necessary", and the second is to be ". . .a full hearing on the need for commitment" (page 84a). In addition to these hearings, the children are provided the rights of prior notice, free counsel,[4] as well as confrontation and cross-examination of adverse witnesses. Finally, the lower court ordered that all children presently receiving treatment in any of the hun-

[3] The plaintiff classes have been defined as:

> (a) all juveniles committed as mentally ill to mental health facilities in Pennsylvania who are under the age of fourteen;
>
> (b) all juveniles committed as mentally retarded to mental health facilities in Pennsylvania who are age eighteen or younger. (page 84a)

The district court also certified a defendant class composed of:

> The directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare (page 85a).

[4]The Order refers to a "trained representative" as an acceptable alternative to counsel however in the context of all of the mandatory formalities of the hearings established by the District Court, it is difficult to imagine how a non-lawyer could effectuate and protect all of the rights provided to the children.

dreds of facilities in Pennsylvania either be discharged or readmitted pursuant to those procedures within one hundred and eighty days. Shortly after the District Court's Order was entered this appeal was initiated seeking review of both the declaratory and injunctive aspects of the order.

THE QUESTIONS ARE SUBSTANTIAL

I. DID THE LOWER COURT ERR BY CONCLUDING THAT BOTH THE 1966 AND 1976 ACTS VIOLATE THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT WITH RESPECT TO THE ADMISSION OF CHILDREN TO MENTAL HEALTH FACILITIES?

A. *Liberty Interest:*

Pennsylvania, like most other states, allows parents to seek medically recommended inpatient mental health or retardation services for their children without suffering the intrusion and trauma of adversarial proceedings. Pennsylvania's recognition of these parental prerogatives finds strong and conclusive support in the decisions of this Court. In *Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); and *Meyer v. Nebraska*, 262 U.S. 390 (1922), this court has been steadfast in its refusal to permit governmental intrusions into the private realm traditionally reserved to the family. Thus, the court noted in *Stanley v. Illinois* that:

> The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed 'essential,' *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923), 'basic civil rights of man,' *Skinner v. Oklahoma*, 316 U.S. 535, 541, (1942), and '[r]ights far more precious. . .than property rights,' *May v. Anderson*, 345 U.S. 523, 533 (1953). 'It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.' *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). The integrity of the family unit has found protection in the Due Process Clause of the Fourteenth

Amendment, *Meyer v. Nebraska,* supra, at 399, the Equal Protection Clause of the Fourteenth Amendment, *Skinner v. Oklahoma,* supra, at 541, and the Ninth Amendment, *Griswold v. Connecticut,* 381 U.S. 479, 496 (1965) (Goldberg, J., concurring).

Stanley v. Illinois, 405 U.S. 645 (1972) at 651.

Nevertheless, the district court ignored these precedents and erroneously concluded that the plaintiff children possessed a sufficient liberty interest to implicate the Fourteenth Amendment. This conclusion was bottomed on a line of cases reflected in *In Re Gault,* 387 U.S. 1 (1966) which dealt with the peculiar problems of the juvenile justice system. These decisions have no application here however, because this simply is not a situation where the state is attempting to impose criminal sanctions on the child for violations of law. To the contrary, this case presents a conflict between the wishes of the child and those of his parents and physicians. Viewed in its proper light, the lower court's finding that the plaintiffs possessed a protectable liberty interest in this case runs afoul of generations of precedents in this Court. In short the district court found a liberty interest where none exists.

B. *State Action:*

The mere fact that state law outlines the procedures for admission to a mental health facility, notwithstanding that the state may, in a particular situation, do no more than "approve" the facility, was apparently enough for the lower court to find "state action" sufficient to implicate the Fourteenth Amendment (page 68a and page 69a). In Pennsylvania the role of the state in the admission process varies, ranging from actually initiating the admission, to doing nothing more than licensing the facility.[5]

---

[5] The record indicates that only 10% of the children in state facilities were admitted by state agencies.

This Court has pointed to several earmarks of "state action", none of which exist in most, if not all, of the circumstances present in this case. *Moose Lodge No. 107 v. Irvis,* 407 U.S. 163 (1972); *Adickes v. S. H. Kress Co.,* 398 U.S. 144 (1970); *Burton v. Wilmington Parking Authority,* 365 U.S. 715 (1961). It is clear from these cases that the mere "approval" of a facility to provide a service to the public, without more, does not begin to approach the level of activity required to find "state action". Nevertheless the lower court ignored all the variations in the level of state involvement in the admission process from one facility to the next, and concluded there was sufficient state action across the board. This conclusion was certainly erroneous and should be reversed.

C. *The Process Due:*

After finding that the plaintiffs possessed a liberty interest which was adversly affected by actions of the defendant officials, the court concluded that the existing statutory procedures were constitutionally deficient (page 75a). In place of the statutory procedures, the court detailed a procedure for admissions that includes the rights to, not one, but two adversary proceedings, free representation, presentation of evidence, and confrontation and cross-examination.

The actions of the district court in this respect warrant reversal for two reasons. First, the court failed to recognize that under the tests established by this Court, the current Pennsylvania procedures for the admission of juveniles adequately balance *all* of the competing interests, including those of the child. *Bd. of Curators of University of Mo. v. Horowitz,*.....U.S. ....., 98 S. Ct. 948 (1978); *Smith v. Organ. of Foster Families For E. & Reform,* 431 U.S. 816 (1977). Secondly the procedures ordered by the lower court provide no greater measure of protection to the child's interests than is presently afforded by the statutes and regulations.

Thus, whatever the validity of the court's reasoning, there is no doubt that its order must be vacated.

The relief provided by the district court rests on several fundamental and erroneous assumptions. First, and without any real evidence indicating such to be the case, the court assumed that diagnoses in the mental health area were unusually prone to error (page 74a). Compounding this error, the court ordered that every diagnosis and treatment plan be scrutinized much the same as the guilt of an accused is determined. The questionable value of such proceedings in the mental health field has been aptly noted by courts and scholars alike. Similarly, the court erroneously assumed that parents possess an inherent conflict of interest with their children when, upon medical recommendation, they seek this type of health care for their children. Once again the error is exacerbated by establishing a series of procedures which are guaranteed to produce conflict and trauma within the family. Thus, even assuming the existence of the due process deficiencies detected by the lower court, the relief ordered falls far short of its mark and should be vacated.

The question raised by this appeal are extremely important and fraught with difficulties. In fact, there is presently a case listed for reargument before this Court raising similar issues. *Parham, et al. v. J.L. and J.R.*, No. 75-1690. While the *Parham* case raises similar issues as those presented in this appeal, there are differences which necessitate the review of both decisions by this Court. For example in *Parham* only mentally ill children were involved, while in this case both the mentally ill and the mentally retarded are concerned. In addition, the lower court in this case specifically included private facilities within the ambit of its ruling, while only public facilities are apparently involved in *Parham. J.L. & J.R. v. Parham*, 412 F. Supp. 112 (M.D.Ga. 1975). Finally, the statutory schemes involved differ significantly. Thus in

Pennsylvania specific substantive and procedural rights have been afforded juveniles which are absent in the Georgia statutes. See e.g. 6 Pa. Bull. No. 38, Sept. 4, 1976 at 2119 (patient bill of rights). For all of the foregoing reasons it is therefore respectfully urged that this case again warrants review by this Court. And for the reason already highlighted, as well as those that follow, the lower court's ruling must be reversed.

II. DID THE LOWER COURT ERR IN PLACING THE PLAINTIFFS AND DEFENDANTS IN SINGLE CLASSES?

This Court noted an ". . .obvious lack of homogeneity" in the plaintiff class in the original appeal in this matter. *Kremens v. Bartley*, 431 U.S. 119, 130 (1976). After reviewing but a few of the observable differences in the plaintiff class, this Court concluded that ". . .we have the gravest doubts whether the class, as presently constituted, comports with the requirements of Fed. Rule Civ. Proc. 23(a)." *Id.* at 132. Consistent with those doubts, the district court was urged to "stop, look, and listen" before certifying a class. It was urged to consider the 1973 regulations, the overall distinctions between the young and the very young, as well as between the mentally ill and mentally retarded.

Notwithstanding all of this cautionary advice, the lower court concluded that none of those factors warranted a revision of the original class (page 72a). It is true that the class is defined in terms of subclasses for the mentally ill and the mentally retarded, but this is meaningless because the analysis applied, and the relief ordered make absolutely no distinctions between the two. In short, the young and very young, and the mentally ill and the retarded have once again been erroneously lumped together and given the same treatment

despite the very real differences that exist, and have been pointed out by this court. Premised upon a short sighted due process analysis the treatment given to the plaintiff class simply does not meet the requirements of Fed. Rule Civ. Proc. 23, and must accordingly be set aside.

On the basis of this flawed due process reasoning the district court this time also certified a defendant class of all directors of mental health facilities in Pennsylvania. This class is comprised of directors of public and private facilities regardless of the degree of state involvement with the facility. Similarly, the class does not distinguish between facilities that may only deal with mildly afflicted youngsters for very short term therapy, and facilities that provide long term care for the more severaly handicapped. Once again the premise for the court's action is faculty and must be set aside.

III. ARE THE RETROACTIVE ASPECTS OF THE INJUNCTIVE RELIEF GRANTED BY THE LOWER COURT IMPROPER?

A. *The Eleventh Amendment:*

The District Court's mandate that Pennsylvania provide the full panoply of due process rights retroactively to those thousands of children who, at the time of the order, were receiving inpatient care violates the Eleventh Amendment. In *Edelman v. Jordan,* 415 U.S. 651 (1974), this Court set aside a retroactive award of certain welfare benefits wrongfully withheld by state officials. This Court recognized that such awards of retroactive relief could reap havoc with a state's fiscal soundness—the primary evil targeted by the framers of that amendment. See e.g. *Chisholm v. Georgia,* 2 Dal. 419 (1793).

In this case the retroactive relief has the critical

indicia of an illegal award that were noted in *Edelman.* Initially, the large sums of money which will be necessary to provide the thousands of hearings with appointed counsel for the child will inevitably come from Pennsylvania's general treasury, rather than from the individual defendants. Id. at 664-665. And finally, the retroactive relief in this case was not merely ancillary to, and the necessary result of ". . .compliance with [a] decree which by [its] terms was prospective in nature." Id. at 668. Thus, as the foregoing indicates, this aspect of the district court's cannot stand.

B. *Exhaustion of State Remedies:*

In Pennsylvania the right of anyone, without distinctions as to age, to seek release from custody in a mental health facility is firmly established. 50 Pa. Stat. Ann. §4426 provides that "[e] very person committed or detained in a facility by reason of the provisions of this act. . ." may avail himself of the remedy of *habeas corpus.* In addition, the 1976 Act provides that any responsible party may, with the assistance of counsel, petition the juvenile division of the court of common pleas seeking to withdraw any child from voluntary treatment. 50 Pa. Stat. Ann. §7206.

Notwithstanding the availability of *habeas corpus* and similar remedies, the plaintiffs chose to seek their release from custody by way of this civil rights action. The district court also ignored these remedies, assumed jurisdiction of the matter, and ultimately ordered the release of every child presently receiving inpatient treatment in a mental health facility (page 59a).

In all of this, the lower court and plaintiffs overlooked this Court's holding in *Preiser v. Rodriguez,* 411 U.S. 475 (1973). In *Preiser* state prisoners sought restoration of certain "good time credits" to their sentences. The effect of this claim, had they succeeded, would have been to shorten or terminate their confinement. In short,

they were charging that they were ". . .being unlawfully subjected to physical restraint. . ." Id. at 486. This Court concluded in *Preiser*, as it must here, that the exhaustion requirements of 28 U.S.C. § 2254 barred the issuance of such relief. The plaintiffs challenge in this case, as in *Preiser*, was clearly within the "core of *habeas corpus*" and therefore was improperly allowed by the district court, and should therefore be overturned by this Court.

CONCLUSION

Based upon the foregoing arguments and authorities it is requested that this Court note jurisdiction in this appeal, receive full briefs on the merits, and hear oral argument in order to resolve the substantial questions which are involved. In addition, it is respectfully suggested that this case be set down for oral argument the same day as arguments are to be scheduled in *Parham et al. v. J.L. & J.R.*, No. 75-1690.

Respectfully submitted,

(s) NORMAN J. WATKINS
Deputy Attorney General

J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation

ROBERT P. KANE
Attorney General

Dated: May 26, 1978

IN THE SUPREME COURT OF THE UNITED STATES

No. A—

SECRETARY OF PUBLIC WELFARE, et al.,
Appellants

v.

INSTITUTIONALIZED JUVENILES, et al.,
Appellees

CERTIFICATE OF SERVICE

I, NORMAN J. WATKINS, do hereby certify that I have served by United States Mail, postage prepaid, first class, on this date, Friday, May 26, 1978, three typed copies of Appellants' Jurisdictional Statement and Appendix to David Ferleger, Esquire, 2321 Sansom Street, Philadelphia, Pennsylvania, 19103. I further certify that all parties required to be served in this appeal have been served.

(s) NORMAN J. WATKINS
Deputy Attorney General

Dated: May 26, 1978

Supreme Court, U. S.
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In the Supreme Court of the United States

No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, FRANK BEAL; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

APPENDIX TO JURISDICTIONAL STATEMENT

NORMAN J. WATKINS
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COMPLAINT—NOVEMBER 2, 1977

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

INSTITUTIONALIZED JUVENILES, et al.,
Plaintiffs

v.

SECRETARY OF PUBLIC WELFARE, et al.,
Defendants

C.A. No. 72-2272
(formerly captioned Bartley v. Kremens)

PLAINTIFFS' MOTION TO AMEND AND SUPPLEMENT COMPLAINT

Pursuant to Rules 15(a) and 15(d) of the Federal Rules of Civil Procedure, plaintiffs respectfully move the Court for leave to amend and supplement their complaint in this action for the purpose of adding new and proper class representatives and to advise the Court of recent state statutory developments.

After final judgment in this action, the Supreme Court vacated and remanded this Court's Order so that the above matters might be considered. *Kremens v. Bartley*, 97 S.Ct. 1709 (1977).

Defendants' counsel has informed the undersigned that he has no objection and consents to the above requested amendment and supplementation. Plaintiffs do not intend to file any memorandum in support of this motion, unless the Court should request one.

Respectfully submitted,
David Ferleger, Esquire
2321 Sansom Street
Philadelphia, Pa. 19103
215—567-2828, 735-8409

November 2, 1977

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

INSTITUTIONALIZED JUVENILES, et al.,

Plaintiffs

v.

SECRETARY OF PUBLIC WELFARE, et. al.,

Defendants

C.A. No. 72-2272

CERTIFICATE OF SERVICE

David Ferleger, Esquire, counsel to the plaintiffs, hereby certifies that on the 2d day of November, 1977, he mailed true and correct copies of the Amended and Supplemental Complaint, Motion to Amend and Supplement Complaint, and Interrogatories to the Defendants by first class U.S. mail, postage prepaid, to all counsel herein to the following addresses:

Norman Watkins, Esq.
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COMPLAINT—NOVEMBER 2, 1977

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Plaintiffs

v.

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, Frank Beal; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Defendants

C.A. No. 72-2272
(formerly captioned Bartley v. Kremens)

AMENDED AND SUPPLEMENTAL COMPLAINT

I.
PRELIMINARY STATEMENT

1. Children are persons under the Constitution and laws of the United States and are entitled to their protection.

2. Plaintiffs, individually and on behalf of all others

similarly situated, seek declaratory and injunctive relief for violations of their civil rights resulting from the operation of Pennsylvania statutes which permit their indeterminate confinement in institutions for the mentally ill and mentally retarded under color of state law with no right to notice, hearing, counsel and other procedural safeguards. The statutes are challenged on the ground that they conflict with the plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

3. The defendants are those state officials who accept and receive into involuntary custody the plaintiffs, minors, upon the request of parents or guardians such as welfare departments and child care agencies.

4. This case has been before the Court as *Bartley v. Kremens*, 402 F.Supp. 1039 (E.D.Pa. 1975), vacated and remanded, 97 S.Ct. 1709 (1977). This amended and supplemental complaint substitutes new class representatives and informs the Court of recent state statutory developments.

II.
JURISDICTION

5. Jurisdiction is conferred upon this Court by 28 U.S.C. 1331 which provides for original federal question jurisdiction. The amount in controversy, exclusive of interest and costs, exceeds $10,000.

6. Jurisdiction is also conferred upon this Court by 28 U.S.C. 1343(3) which provides for original jurisdiction in all suits authorized by 42 U.S.C. 1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States and by federal law. Defendants here act under color of state law.

7. Plaintiffs' action for declaratory and injunctive relief is authorized by 28 U.S.C. 2201, 2202, 2281, 2284, Rules 57 and 65 of the Federal Rules of Civil Procedure, all of which relate to declaratory judgments, injunctions and three-judge courts, and by 42 U.S.C. 1983 and 1988, which relate to civil rights actions.

III.
THREE-JUDGE COURT

8. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. 2281 and 2284 since the plaintiffs seek an injunction to restrain defendants, state officials, from the enforcement, execution and operation of portions of state statutes of statewide applicability on the ground that said statutes are contrary to the United States Constitution. This action was filed prior to the enactment of Public Law 94-381, which amended the three-judge court statutes.

IV.
CLASS ACTION ALLEGATION

9. The named plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a) 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

10. The members of the class of plaintiffs similarly situated are all persons who are or who may be committed to institutions for the mentally ill and the mentally retarded in Pennsylvania upon application of parents or guardians and without notice, hearing, counsel and other procedural safeguards.

a. Subclass A of plaintiffs includes all those persons under 14 years of age committed under

Section 201 of the Mental Health Procedures Act of 1976.

b. Subclass B of plaintiffs consists of all persons 18 years of age or younger committed under Sections 402 and 403 of the Mental Health and Retardation Act of 1966.

11. The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical (and the total membership of the class is indeterminate); there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

12. Defendants John Fong, C. Duane Youngberg and Nicholas D'Aluisio, directors of the facilities confining the named plaintiffs, are sued as representative of the class of directors of all mental health and mental retardation facilities in Pennsylvania, all of which are subject to regulation by the defendant Secretary of Public Welfare. All the allegations in Paragraph II are met with respect to this defendant class and those allegations are incorporated here by reference.

13. The questions of law and fact involved are:

a. Are the representative parties, and their class members, committed to mental institutions pursuant to the challenged statutes and without notice, counsel, hearing and other procedural safeguards?

b. Do the defendants operate, execute and enforce the challenged statutes?

c. Are the challenged statutes contrary to the Due Process Clause of the Fourteenth Amendment to the United States Constitution?

V.
NAMED PLAINTIFFS

14. The named plaintiffs sue by their next friend and guardian ad litem, appointed by this Court pursuant to Rule 17 of the Federal Rules of Civil Procedure.

15. Due to the stigma of mental hospitalization and a desire to minimize any possible intrusions on their privacy, the named plaintiffs are designated in this complaint by their actual given names and the initial of their surnames. The full names of the plaintiffs are being disclosed to the defendants and their counsel and will, should the Court desire, be filed with the Court.

16. The first group of plaintiffs, those confined at Haverford State Hospital under the Mental Health Procedures Act of 1976, are *all the juveniles age 14 and under committed under Section 201 as of October 31, 1977 to that institution.*

17. The second group of plaintiffs are persons with mental retardation confined under the Mental Health and Mental Retardation Act of 1966, Sections 402 and 403 in two institutions, one near Philadelphia in the eastern part of Pennsylvania and one near Pittsburgh in the west.

First Group of Plaintiffs; Those at Haverford State Hospital

18. Plaintiff Kevin S., born May 2, 1965, is a citizen of Pennsylvania. He is 12 years old.

19. Plaintiff Richard S. is now 13 years old and a citizen of Pennsylvania. He was born on September 24, 1964.

20. Plaintiff James Paul M. is 7 years old, having been born on November 10, 1969. He is a citizen of Pennsylvania.

21. There is no paragraph 21.

22. Plaintiff Raymond C. was born on September 9, 1964, is a citizen of Pennsylvania, and is 13 years old.

23. Plaintiff William B. was born June 18, 1968, is 9 years old and is a citizen of Pennsylvania.

24. Plaintiff Eddie B. was born October 26, 1965, is a citizen of Pennsylvania and is 12 years old.

25. Plaintiff Francis B. was born January 9, 1967, is 10 years old, and a citizen of Pennsylvania.

26. Maria L., plaintiff in this action, was born August 26, 1965, is 12 years old and a citizen of Pennsylvania.

27. Thomas W., born February 14, 1966, is 11 years old and a citizen of Pennsylvania.

Second Group of Plaintiffs; Those at Pennhurst and Polk State Schools and Hospitals

28. Plaintiff Nancy Louise D., born December 10, 1960, is a 16 year old citizen of Pennsylvania.

29. Plaintiff Gina S. was born on July 30, 1961 and is a citizen of Pennsylvania. She is 16 years of age.

30. Plaintiff George S. was born February 10, 1963, is 14 years old, and is a citizen of Pennsylvania.

VI.
DEFENDANTS

31. Defendant Secretary of Public Welfare is the Pennsylvania State official who, in that capacity, has the power and duty to enforce the challenged statutes and all regulations necessary and appropriate to the proper accomplishment of those provisions and to operate and assign functions to all state facilities. See Sections 201(2) and 202(a) of the Mental Health and Mental Retardation Act of 1966, and Section 105 of the Mental Health

Procedures Act of 1976 ("Treatment Facilities"), and 6 Pa.Bull. 2115 at Section 7100.1.2 (definition of "approved facility"). Frank Beal currently occupies that office.

32. Defendant John Fong is the director of Haverford State Hospital and is charged with supervision and administration of the facility. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act of 1966. It is to Fong or his delegate that applications for admission, commitment or release of the plaintiffs must be made. Haverford State Hospital is an approved facility under Section 105 of the Mental Health Procedures Act of 1976.

33. Defendants Nicholas D'Aluisio and C. Duane Youngberg are, respectively, directors of the Polk State School and Hospital and the Pennhurst State School and Hospital, both institutions for persons with retardation. They are charged with supervision and administration of those facilities. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act of 1966. It is to D'Aluisio, Youngberg or their delegates that applications for admission, commitment or release of the plaintiffs must be made. See Sections 402(b), 403(b) and 403(c) of the Mental Health and Mental Retardation Act of 1966.

VII.
FACTUAL ALLEGATIONS

Haverford State Hospital

34. Haverford State Hospital is an institution for the mentally ill located in a rural area outside Philadelphia, Pennsylvania.

35. The institution's score of buildings cover a large hilly area in one corner of which is Building 14, a build-

ing with two large wards. The west ward houses geriatric patients; the door to it is generally unlocked. The east ward houses juveniles.

26. As of October 31, 1977, there were a total of 12 juveniles in Building 14. Two were committed by juvenile courts, after hearings; ten were committed under the challenged statutes, having been "volunteered" into the institution by parents or guardians.

27. Entry into the Children's Unit in Building 14 is through a door that is kept locked. When a buzzer is rung, a worker inside comes to unlock the door. The door bears a sign which reads, "VISITING HOURS—1:30 - 4:30 Weekends and Holidays. No evening visits. (signed) Dr. Bernard Kanther."

28. The Unit consists of two hallways which cross at a glass-walled nursing station. One hallway continues from the entrance door to a large dormitory area for male patients. Along that hallway are two bare unfurnished rooms used for "seclusion" or "time-out" purposes. The second hall has a large dayroom at one end and, at the other end, a large dormitory for female patients.

29. In the nursing station is a bank of television monitors which are used to surveil the patients in all areas of the Unit, including the halls and dormitories.

30. Adjacent to the building are playing areas fenced in by chain link fences about 12 feet high.

32. Patients, including the plaintiffs, are punished for misbehavior and for disobedience to staff, and for violations of unit rules in a variety of ways including: restriction to the Unit, "meditation" (an enforced period of standing or sitting in the hallway, with the person forbidden to converse or interact with other patients passing to and fro), or "time-out" (lock-up in a bare unfurnished room, including overnight periods, alone).

33. Patients have also been pushed, shoved, slapped and hit by institutional staff with no justification. Patients have been forcibly medicated with intra-muscular injections as punishment for "acting out" and for the convenience of staff. The plaintiffs have been subjected to these conditions.

34. Aides and attendants are given great power and discretion to impose restrictions on the plaintiffs. Often this is done arbitrarily with no opportunity provided for appeal or review of such decisions.

35. Privileges (such as the opportunity to exercise outside), special events, and even some forms of therapy may be denied to plaintiffs for violations of Unit rules.

36. Unit rules include, inter alia, prohibitions against chewing gum, smoking, name-calling, visiting with parents or others in the dormitories.

37. The admission process includes a pre-admission contact or interview with a social worker and other staff (this may be the same day as admission) and an interview of the child by a psychiatrist, recorded in an admission note on the day of admission. The admission note summarizes the factual and psychiatric basis thought to justify the commitment.

Kevin S.

38. Plaintiff Kevin S. was admitted to Haverford State Hospital on July 18, 1977 pursuant to Section 201. He was born May 2, 1965. He was brought to the facility by his mother and the county child care agency.

39. A July 25, 1977 evaluation conducted by the school at which Kevin S. was in the fifth grade provides as a "diagnostic impression" of him:

> Kevin is a very needy, very angry boy who needs a supportive and consistent environment. He is not currently seen as psychotic although there is a tendency toward projection and a lack of controls when anxious. A behavior disorder of childhood is suggested. It should be noted, however,

that the emergence of adolesence with its attendant conflicts and changes will, in all likelihood, throw additional strains upon the defenses of an already disturbed child.

40. Kevin's mother is separated from her husband, who lives in New York. His brother, born in 1963, is in a foster home.

41. Kevin's mother has a history of serious mental illness and hospitalizations. She has also physically abused Kevin. As a result of these problems, most of Kevin's early life (he was born in a mental hospital) was spent in foster homes. Haverford State Hospital's psycho-social history describes the facts in this regard:

> She Kevin's mother has many schizophrenic-type features, such as tangential thinking, flight of ideas, inappropriate laughter and illogical statements. During the pre-admission interview there were several times when Kevin's response was much more appropriate than was his mother's. When we told the Squires that we could set an admission date, Mrs. Squires covered her face with her hands and made loud and wracking sobs for several seconds, then immediately stopped and, with no sign of emotion, exclaimed that Kevin's admission should be the sooner the better! This sort of behavior was rather inappropriate. However, she does have a caring for Kevin and expresses hope and a positive attitude that she and Kevin will be helped.
>
> *Reason for Hospitalization:* Kevin was admitted on a voluntary 201a admission, signed by his mother,.....S. Kevin has a history of much instability within the family. He was born in a state mental hospital, as his mother had requested admission there because she trusted the doctors. He was in a foster home for his first five months while his mother was in the state hospital. He subsequently was in another foster home for a few weeks, when he was seven years old (along with his brother), and again in 1971. He was in another foster home from August 1974, to May, 1975, and in another home for a period of two years. Mrs. Squires would place the children because she physically abused them. She was having emotional and marriage difficulties and could not handle Kevin properly.

42. Shortly before his commitment to the institution, school authorities objected to his behavior there; he was allegedly making wierd noises, refusing to do work, and talking back to teachers. He was suspended from school. At home, his mother felt, he was hyperactive, and spent much time playing by himself.

43. During her fifteen years of marriage, Kevin's mother was in a mental hospital many many time; she attempted suicide twice before her children were born. As with Kevin, she was in a mental hospital when her elder son was born. When pregnant with Kevin, she returned to the hospital and, she told Haverford State Hospital staff, "lied" to get in again.

44. Kevin's brother, thirteen months his senior, had been in a foster home but at the time of Kevin's admission to Haverford was in a foster home in New York under the custody of a county social services department. He too had been in a mental hospital.

45. The impression of the institution social worker was, "It is felt that much of Kevin's problems come from living with a schizophrenic mother and having a very unstable and confused early life." The social worker noted that that Mrs. S actively uses social systems "to the point of abuse."

46. The decision to admit Kevin S. to the institution was made at a meeting at the hospital on July 13, 1977

with hospital staff and a representative of the county child care agency. An admission date of July 18, 1977 was set. No psychiatric report or evaluation was made during that pre-admission interview.

47. After he was admitted, on July 18, 1977, Dr. Mia Marcovici interviewed Kevin S. and filed the following "Admission Note:"

> *REASON FOR ADMISSION:* Difficulties adjusting to school and family (mother). Exhibited bizarre behavior in school that has included making inappropriate sounds and laughing inappropriately.
>
> *MENTAL STATUS:* (Use 2d page if necessary) Kevin is a 12 years, 2 month old boy who was accompanied to the hospital by his mother and Yol Sanders from the Delaware County Child Care Service. He was clean in his appearance and was generally cooperative. He had difficulty sitting still and concentrating on a topic. He was well oriented and spoke in short sentences. It appears that he spends a lot of time in his room building walls or playing with his cars. He has few friends and has difficulties relating to peers. No thought disorder was elicited and denied hallucinations.

The "diagnostic impression" noted after this note was "Withdrawal Reaction of Childhood. 308.1."

48. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 2d Edition* (hereafter, "DSM-II) defines this diagnosis as follows:

> 308.1* Withdrawing reaction of childhood (or adolescence)*
>
> This disorder is characterized by seclusiveness, detachment, sensitivity, shyness, timidity, and

> general inability to form close interpersonal relationships.

49. There is no indication in the records of Kevin's admission to Haverford State Hospital of his comments or version of the behaviors he was accused of.

Richard S.

50. Richard S. is a Black youth, age 12, who was committed to Haverford State Hospital on June 6, 1966 pursuant to Section 201 by the county child care agency which had and has legal custody of him. He was born on September 24, 1964.

51. There had been a previous attempt to have him admitted to the Adolescent Unit of the same institution but he had not been accepted because of his size and age.

52. Richard S. did not live with his mother until he was two years old (he was under an agency's care) and lived with her at home only until he was four when he was placed in the child care agency's Children's Cottage. He later lived in another institutional home for children and then at a residential school for difficult students, at which he was placed immediately prior to his commitment to the mental hospital.

53. Prior to his admission, a contact was made with the Haverford State Hospital at which the hospital authorities were told that Richard's problems included "running away from Silver Springs, putting glass in eye, striking resident while asleep, shaving head and breaking car windshield."

54. The staff of the school Richard was in recommended hospitalization to the child care agency which, in January, 1977, six months before his admission, wrote to Haverford seeking his commitment.

55. The first psychiatric evaluation recorded for Richard S. in the hospital records is dated June 6, 1977

by Dr. Miz Marcovicci and states as follows:

REASON FOR ADMISSION: Inability to adjust to an open setting. History of self harm and running away.

MENTAL STATUS: (Use 2d page if necessary) Rickey is a well developed, 12 year 8 month old boy. He is clean and neat in his appearance. He is well oriented in all three spheres. Ricky looks down to the floor most of the time. His eye contact is limited and he offers no spontaneous conversation. When asked questions he replies in short sentences. He is relevant and coherent. He appears preoccupied. No bizarre or inappropriate behavior was elicited. No restlessness or fidgitness was noticed. He has a history of low impulse control, self harm, running away and unpredictable behavior.

The diagnostic impression was "Unsocialized Aggressive Reaction of Childhood."

56. This diagnosis is defined in the *DSM-II* as follows:

308.4* Unsocialized aggressive reaction of childhood (or adolescence)*

This disorder is characterized by overt or covert hostile disobedience, quarrelsomeness, physical and verbal aggressiveness, vengefulness, and destructiveness. Temper tantrums, solitary stealing, lying, and hostile teasing of other children are common. These patients usually have no consistent parental acceptance and discipline.

57. The admission records at Haverford do not indicate Richard S's version of the behavior of which he was accused. The only "self harm" indicated is the unexplained reference to "putting glass in eye."

58. Within a few days of admission, Richard S. expressed his desire to leave the institution; no attempt

was made by institution staff to provide him with an attorney or to advise him of steps to take to obtain his release.

59. By October, 1977, his diagnosis was changed to "Withdrawing reaction of childhood", defined above.

60. The institution's doctor at Haverford prescribed the drug Thorazine to be administered by nurses, without further doctor's order, for any aggressive behavior.

James Paul M.

61. James Paul M. was born November 10, 1969 and was admitted at age 7 to Haverford State Hospital under Section 201 on October 17, 1977

62. The admission note by Dr. Elizabeth Cheek states as follows:

REASON FOR ADMISSION: Uncontrollable behavior. Learning disability.

MENTAL STATUS: (Use 2d page if necessary) This eight year old youngster looked cheerful in the beginning but was clinging to the father later on. He was dressed in pair of jeans and a T-shirt. Speech was clear and understandable. There were no abnormalities of gait. Patient was sucking his thumb in the beginning and said, "I am not answering. My Dad will do." He used the phrase "Oh Brother" with a sigh for every sentence. Patient did not sit on a chair for more than 1 minute and changed toys very frequently. Patient was oriented to time, place and person. Pat has vague memories of past but was able to tell about recent things. He cannot remember the immediate things which were asked to repeat. He was short attention span, get frustrated with the toys very easily. Patient was not sure of the side? He did not like the idea of separating from father. Patient gets very anxious if he hears any voice outside. He feels that he should punch everybody if he cannot

get things done. He sat very near the father later on.

The diagnostic impression was "Minimal brain dysfunction, learning disability."

These diagnoses are not defined or listed in the *DSM-II*.

63. On his first day at the institution, the doctor prescribed the use of Thorazine. During Paul's first week, he was placed in a locked bare room alone, on an "as is necessary basis," on the discretion of non-medical staff.

64. Prior to this admission, Paul had been asked to leave school. At home all day, his behavior deteriorated. His mother died about a year ago. His father works all day.

Edward B.

65. Edward B., born October 26, 1965, was committed to Haverford State Hospital on May 9, 1977 by his father. He was referred to the institution by his psychiatrist who, it happens, is also a full-time psychiatrist in another unit at Haverford State Hospital.

66. Five days before admission, the referring psychiatrist and the parents of Edward B. reported to the social worker that the child had "acted out" at home and in the community. The only specific behavior reported or alleged was that he had thrown a rock through a "window that borders the school" in April, 1977.

67. At this pre-admission meeting, the parents further reported that

> they are policing the boy for fear of his running away, hurting self or others. They are quite concerned that an admission might be necessary when he comes for pre-admission 5/29/77 as they live in neighborhood, and the children call Haverford State Hospital a place for "retards or crazies." Neighbors are now suggesting that Ed is responsible for incidents of destruction in the neighborhood.

68. Edward is an adopted child.

69. The admission note by Ora Smith, M.D. of May 9, 1977 states:

> *REASON FOR ADMISSION:* Hyperactive with poor behavioral controls; threatens to hurt himself; feels depressed.
>
> *MENTAL STATUS:* (Use 2d page if necessary) This 11 year old boy is alert, oriented; and anxious and fearful about hospitalization. Has had a long history of disruptive behavior which is partially controlled by medications.

The "diagnostic impression" recorded in this note is as follows: "minimal brain dysfunction, adjustment reaction of childhood."

70. Minimal brain dysfunction is not defined in the *DSM-II*. Adjustment reaction of childhood is defined as follows:

> 307.1* Adjustment reaction of childhood*
>
> Example: Jealousy associated with birth of patient's younger brother and manifested by nocturnal enuresis, attention-getting behavior, and fear of being abandoned.

The *DSM-II* notes that this and certain other diagnoses are "transient situational disturbances" which "occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress."

71. During the many months of his commitment with a diagnosis indicating a short-term problem, the hospital records and evaluations continued, each month, to state an "anticipated discharge date" of "three months." Paragraphs 84-86 below refer to this plaintiff.

Raymond C.

72. Raymond C., born September 9, 1964, was committed by his father to Haverford State Hospital at age 13 pursuant to Section 201.

73. He was referred to a local mental health clinic by his school. The mental health clinic refered him to Haverford State Hospital for residential treatment evaluation.

74. Raymond C., at the time of his admission, was under the jurisdiction of the Juvenile Court, with a background of stealing minibikes.

75. He was admitted to Haverford State Hospital the day he was first seen at that facility.

76. The admission note, dated September 28, 1977, and reflecting the examination performed on the day of Raymond's admission, states:

> *REASON FOR ADMISSION:* History of uncooperative disruptive and aggressive behavior including run away from school. Problems in community with stealing and destroying property. Has a learning and hearing problem—Admission and evaluation to assist in future planning to meet his needs.
>
> *MENTAL STATUS:* (Use 2d sheet if necessary)
> An alert, sad and anxious immature looking 13 year old. Patient avoids (refuses) any conversation with adults other than his parents. He does not evidence any overt physical deficits other than hearing. He does not display anything suggestive or psychosis. His lack of cooperation at this time prevents doing a desireable mental status examination.

The diagnostic impression was one of a "behavior disorder of childhood" and a non-psychotic organic brain

syndrome with associated speech, hearing and learning disabilities.

77. Raymond C.'s father had a drinking problem. He died on or about October 30, 1977.

William B.

78. Nine years old, William B. was born on June 8, 1968 and was committed to Haverford State Hospital by his father, pursuant to Section 201, on September 21, 1977.

79. William's parents had separated and divorced when he was an infant. About two years prior to his commitment, he began living with his natural father in a home with his stepmother and two stepbrothers.

80. The admission note by Dr. Mia Marcovicci states:

> *REASON FOR ADMISSION:* Uncontrollable behavior; preoccupied with matches, set a rug on fire, turned the gas burners on in the house, throws things out the window.
>
> *MENTAL STATUS:* (Use 2d page if necessary)
> This 9 years, 3 months old boy was referred to Haverford State Hospital by Media Child Guidance Clinic and Dr. Fittie. He has been in therapy for the past few months and recently his behavior has deteriorated. He turned on gas burners in the house, smears feces and has taken away and hid his youngest brother's injectible medication for allergies (the desensitize lotion vaccine).
>
> Billy is well developed and neat in his appearance. He exhibited no separation anxiety from his parents and was spontaneous and talkative. He talked about the boy in his head who tells him to do bad "things". He claims to hear his voice but did not see him. He was restless, anxious and destructible. He exhibited some inappropriate behavior in the office. Billy is well oriented and coherent.

The diagnostic impression was "overanxious reaction of childhood".

81. This diagnosis is defined in the *DSM-II* as follows:

> 308.2* Overanxious reaction of childhood (or adolescence)*
>
> This disorder is characterized by chronic anxiety, excessive and unrealistic fears, sleeplessness, nightmares, and exaggerated autonomic responses. The patient tends to be immature, self-conscious, grossly lacking in self-confidence, conforming, inhibited, dutiful, approval-seeking, and apprehensive in new situations and unfamiliar surroundings.

82. William B.'s life with family members subjected him to a situation of extreme inconsistency, disorganization and lack of structure. His natural mother's lifestyle was erratic and she reportedly abused him. His grandparents have given him affection but their handling of him has also been destructive to his development.

83. His mother and his grandparents were not told of the plans for his commitment; they were informed after he was institutionalized.

Edward B., Further Facts (see paragraphs 65-71 above)

84. Eddie B. was admitted to Haverford State Hospital on May 9, 1977, by his parents, very upset, as he had been tricked into going by his parents. He was committed under Section 201.

85. The admission note indicates the facts surrounding his entry into the institution:

> From the beginning, Eddie was extremely upset and crying. He was totally unprepared for admission to a hospital. On the way, his parents told him they were taking him to a new school as he could not continue in his present one. Mrs. B..... explained that this problem had existed for some time but that he had not been excluded until recently because she was a teacher in that setting and the school had permitted him to remain. To prevent misunderstanding of why he was here, it was pointed out that this was a hospital and that school was a part of the program rather than the primary reason for the children coming. Because Eddie was so upset, I suggested that one of the teachers tell him a little bit about our school so that he could know this part of the program. Although this was done, Eddie heard very little about what was being said because of the way he had been brought for this admission.
>
> Eddie then opened up with many feelings about being tricked into coming by his parents. He expressed feelings about them not caring for him and wanting to get rid of him. Both parents acknowledged that they had "tricked him" because they were fearful he would run away or threaten to hurt himself. They admitted that they had not told him until that morning and had omitted the fact that his was a psychiatric hospital. Eddie's response to this was to make promises that he would change if he could stay home. * * * Eddie continued with his fears of being in a "crazy" hospital and of getting hurt by other patients—both adults and children. He also spoke of the high fences and of being kept in, like a prisoner. * * *

During this admission interview, Eddie was told he would not be permitted home for a home visit for three weeks to a month. He responded, "My God, you're trying to kill me." To comfort him, the doctor suggested that he could go on a trip the next day with the other children. His parents interjected that they did not trust that he would not run away. The doctor then agreed that he would not go on the trip.

86. Eddie was not told during this admission process that the institution would help him obtain a lawyer or any legal assistance.

Francis B.

87. Francis B., born January 9, 1967, was 9½ years old when he was admitted to Haverford State Hospital on August 16, 1976 pursuant to Section 403 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. 4403.

88. This admission was at the request of his father who signed admission forms which were not filled out, which did not list the son's full name (or, on the Section 403 form, any name at all) or any identifying information whatsoever. On September 7, 1976, the father executed a form under the successor statute, Section 201, asking the hospital to commit Francis B. for care and agreeing that the hospital need not release Francis B., even at the father's request, without at least 72 hours notice.

89. Francis B. comes from a disorganized family which has rejected him. As a social history a month before his commitment indicates, "One of the most distressing aspects of this case is the almost total rejection of Frankie by everyone in his family." His father has a drinking problem, the records indicate that the "parents are in need of help also as there is some question here of physical abuse" and, at the pre-admission interview at Haverford, it was apparent that "Frank could no do right in parent's eyes." There are five children in the family, all boys.

90. The admission note of August 16, 1976 by Dr. Mia Marcovicci which records the psychiatric justification for the commitment notes "difficulties adjusting to school" and that Francis B. "has been described as hyperactive . . . clowning in order to get attention." The diagnostic impression was of "Unsocialized aggressive reaction of childhood," a term the official definition of which is noted above at Paragraph

91. After Francis B. was committed, the institution received background an referral material including a psychiatric evaluation which indicated that "The school seems to tolerate this boy fairly well" and that, despute the "hyperactivity" attribution, "I cannot describe him as hyperactive. In the first interview his mother seemed more hyperactive than he did."

Maria L.

92. Maria L., born August 26, 1965, was committed to Haverford State Hospital on April 25, 1977 by her mother pursuant to Section 201.

93. The admission note by Dr. Mia Marcovicci states as follows:

> *REASON FOR ADMISSION:* Difficulties adjusting to school because of aggressive behavior. Difficulties adjusting within the family.
>
> *MENTAL STATUS:* (Use 2d sheet if necessary) Maria is a 11 year 7 month old girl who came today accompanied by her mother. She speaks freely about her aggressive behavior in school and describes the fights she gets into. She does not respond to limits at home.
>
> She is restless and fidgity. She is well oriented and relates well to the examiner. No bizarre or inappropriate behavior was elicited. She claims that she will miss her brother Danny (suffers from muscular dystrophy) because "we get in trouble together". She does not appear remorseful about her behavior.

The dignostic impression was "Unsocialized Aggressive Reaction of Childhood. 308.4"

94. Maria L. has resisted the regimentation and direc-

tions imposed upon her by the institutional staff; one staff note quotes her as saying, during a meeting with staff and her mother, "I don't have to listen to these staff people, they're not my parents."

Thomas W.

95. Thomas W. was committed to Haverford State Hospital on an emergency commitment which was later changed to a commitment under Section 201. He was institutionalized at that facility on June 2, 1977.

96. Born February 14, 1966, Thomas' parents have an unstable marriage. After a severe beating which resulted in his hospitalization in 1975, Thomas' case came to the attention to social service agencies and his mother and stepfather were arrested.

97. The county child care agency, which has custody of Thomas W., committed him to Haverford from the County Juvenile Detention Center where he allegedly were divorced, Gina S. was placed in a county "infants several small fires.

98. The admission note for Thomas W. states the basis the facility used for his commitment:

> *REASON FOR ADMISSION:* Fire setting, rages of 5-6 hours, during which he is assaultive, destructive and sets fires.
>
> *MENTAL STATUS:* (Use 2d page if necessary) Patient is a good looking 11 year old black male who is well dressed. He rapidly became angry as I asked him questions. He admits to fire setting and destructive behavior "because they get on my nerves . . . . they get me mad." He appeared quite bright and was adept at standing up for himself. He has been evicted from school for allegedly exhibiting himself and for sexual behavior toward girls. It is also claimed that he has been involved in sexual behavior with his three year old sister and girls in the neighborhood. He denied any sexual behavior except with a nine year old neighbor girl. He denied insomnia, anorexia, depression and self-destructive ideation. He said that the only person he trusted in his family was his three year old sister.
>
> Child Care Worker says he's repeatedly run away, goes into rages of 5-6 hours, has demolished dresser drawers and several windows, pulled a knife on a cottage staff member, has repeatedly been assaultive and was reported to be grunting and evoking unintelligible verbage last night at the detention center. He has repeatedly complained that he has asthma, chest pain and liver trouble but physical was negative.

99. Scapegoated in the home, the professionals involved in his case feel, Thomas acts out the marital and family conflict in his daily life.

100. On May 31, 1977, just two days prior to his commitment to Haverford, Thomas W. was given a psychiatric evaluation by Dr. John Fong, a defendant in this action. Dr. Fong evaluated Thomas W. not as superintendent of Haverford State Hospital but, at the request of a county judge, in his capacity as consultant to the court. He found the child to be non-psychotic but dangerous. He also found that Thomas W. disputed many of the behaviors he was accused of and explained that some were a response to mistreatment. Dr. Fong recommended family therapy, having been informed that admission was being arranged to a private facility. Haverford State Hospital information at the time of Thomas W.'s commitment, however, erroneously stated that Dr. Fong recommended admission. Despite the involvement of the juvenile court and its jurisdiction over Thomas, no court hearing or judicial authorization for the commitment was ever sought or authorized.

Pennhurst State School and Hospital;
.Polk State School and Hospital

101. Pennhurst State School and Hospital is located in a rural area of Pennsylvania near Valley Forge. Built in the first decade of this century, it is an overcrowded and understaffed institution, unaccredited by the Joint Commission on Accreditation of Hospitals. Residents generally receive little habilitative programming. Institutional life for Pennhurst residents is regimented and unpersonalized. The facility houses about 1200 people. The institution and its staff are defendants in *Halderman v. Pennhurst State School and Hospital,* Civil Action Number 74-1345 (E.D.Pa., Tried April - June, 1977, pending decision).

102. Polk State School and Hospital is located in the rural community of Polk, Pennsylvania, approximately 80 miles from Pittsburgh. It is not served by any public transportation. Now housing about 1700 residents, its rated bed capacity is 1321. Polk was built 80 years ago in 1897; those ancient buildings continue to house the plaintiffs in large dormitory areas, residents sleeping head to head. The institutional conditions are regimented and unpersonalized.

Gina S.

103. Gina S. was committed to Polk State School and Hospital on October 20, 1970 by her mother pursuant to Section 404 of the Mental Health and Mental Retardation Act of 1966, which permitted any two doctors to commit any person upon the certification of said doctors.

104. This statute, Section 404, was declared unconstitutional in 1971 in *Dixon v. Attorney General of Pennsylvania,* 325 F.Supp. 966 (M.D.Pa. 1971) (Three-Judge Court).

105. No legal commitment papers were executed

from 1971 until November 25, 1975 (during which time Gina S. remained at Polk) when the plaintiff's mother applied to the defendant director of the institution for plaintiff's commitment under Section 402 of the Mental Health and Mental Retardation Act of 1966.

106. At the age of 6, in 1967, the year her parents were divorced, Gina S. was placed in a county "infants home." Three years later, in 1970, she was removed by her mother and taken directly to Polk where she has remained since.

107. The certificates of the doctors certifying the need for commitment stated as follows:

> a. Certificate No. 1:
>
> (History of illness) Mongolism since birth with moderate retardation.
> (Physical and Mental Findings at Time of Examination— Px as noted. Has limited speech. Child can handle most personal care. She has (illegible) heart disease.
>
> b. Certificate No. 2:
>
> (History of illness) Down's Syndrome—moderate retardation. Fair speech and recognition.
>
> (Physical and Mental Findings at Time of Examination) Typical mongoloid features with high palate, small fifth digit; also with gingival hypertrophy, loud systolic m.

108. The report of the psychologist which accompanied the doctor's reports reported the facts of her condition as follows:

> (Maturation) Gina is an affectionate and alert little girl of moderate mongoloid appearance. Motor development appears adequate, and she was able to deal with all tasks presented from this standpoint.
>
> (Social Adjustment) Gina was cooperative in

the test setting, sitting quietly but responsive to the examiner's questions. Her speech was hard to understand although some single words were very distinct.

(Names of Tests and Results) Stanford-Binet, form L-M: CA: 9-2; MA: 3-4; IQ: 35.

Gina is functioning in the moderately mentally retarded range of intelligence. She can respond well to concrete verbal direction, and is able to use language denotively.

(Diagnosis) Mongolism, AAMD Classification: 64.

Nancy Louise D.

109. Nancy Louise D. was born in 1960. Both her parents were alcoholics. Both her parents were mentally retarded.

110. In 1961, Nancy Louise was adjudicated a neglected child and placed under the guardianship of the county welfare department which placed her in foster care until May 22, 1968 when she was taken directly from foster care to Polk State School and Hospital.

111. On April 12, 1968, the county welfare director executed an application to the defendant director of Polk for the commitment of Nancy Louise to Polk. This was done under the Pennsylvania Mental Health Act of 1951 (*not* the 1966 Act). The child was committed on May 22, 1968.

112. No commitment forms have ever been executed under the Mental Health and Mental Retardation Act of 1966 by the guardian or by anyone else.

113. The defendant director of Polk purports to maintain the confinement of the plantiff pursuant to Section 402 of the Mental Health and Mental Retardation Act of 1966.

114. The basis for commitment, as described in a

physician's certificate attached to the 1968 application is as follows:

(History of Illness) At age 3½ there was marked retardation—did not walk or talk—began walking at about 4½ years.

(Physical and Mental Findings at Time of Examination) Psych. reports will be submitted—obviously retarded—Physical examination essentially neg. except for poor muscular coordination.

George S.

115. George S., abandoned by his parents, was placed at an early age in the custody of the Philadelphia Welfare Department which, by contract, arranged for Catholic Social Services to provide for his care.

116. Catholic Social Services placed him from the first year of his birth until 6 years later (when he was committed to Pennhurst) with a foster family, Mr. and Ms. C.

117. In 1969, the foster mother was hospitalized and, after her discharge, was temporarily not able to resume care of George. As a temporary measure, George was placed in another foster home; however, because of the crowded conditions in that home, the placement could not be maintained. Catholic Social Services, on behalf of the county welfare department, then applied for and was granted commitment to Pennhurst for a short-term period of 90 days.

118. The days lengthened into years; no placement outside Pennhurst was arranged or obtained despite the fact that George could function in a non-institutional setting.

119. George's foster mother, Ms. S., has maintained continual contact with him and attempted to regain care

of him, only to be rebuffed by the institution and the welfare department for no proper reason.

120. During his commitment at Pennhurst, George has suffered numerous bites, scratches and other injuries. One one ward where he lived, he was frequently tied to a bench; he would attempt to walk anyway, dragging the bench after him. Until the last year before the lawsuit referred to in Paragraph 121 was filed, George was constantly naked or wearing clothes that were not his; he never wore shoes or socks on the bare concrete floors of the ward. Pennhurst officials told the foster mother that they medicated George to keep him quiet. On medication, he would sit and rock, his eyes glassy and his attitude sleepy. Off drugs, he is fine and plays and relates to the world.

121. George S. is a plaintiff in *Halderman v. Pennhurst State School and Hospital,* C.A. No. 74-1345, brought to trial in April-June, 1977.

The Statutory Scheme for the Mentally Ill

122. Subclass A, plaintiffs alleged to be mentally ill, are confined to institutions pursuant to Section 201 of the Mental Health Procedures Act of 1977, hereafter, "Section 201." This law became effective September 7, 1976.

123. Section 201, in relevant part, states:

> A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child.

124. There is no time limitation on the length of a commitment under Section 201.

The Statutory Scheme for the Mentally Retarded

125. The members of Subclass B are confined to institutions pursuant to Sections 402 and 403 of the

Mental Health and Mental Retardation Act of 1966, hereafter, Sections 402 and 403, under a scheme described and dealt with by the Court in the earlier phase of this litigation.

126. Sections 402 and 403 provide that applications for admission/commitment may be made by:

> A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

Section 402(a)(2); Section 403(a)(2) (identical language in both sections).

127. There is no time limitation on the length of commitments under Sections 402 and 403.

Commitments of Other Persons in Pennsylvania

128. Aside from the members of the plaintiff class, other persons committed to Pennsylvania institutions for the mentally ill and the mentally retarded do so either voluntarily on their own personal volition or for short-term emergency care or after a judicial hearing at which they have the rights to notice, appointed counsel, presentation of testimony in their own behalf, confrontation and cross-examination of adverse witnesses, expert assistance, court-ordered outpatient or partial hospitalization instead of in-hospital commitment. Many juveniles are committed under the statutory provisions guaranteeing such procedural protections, including juveniles in plaintiffs' situations.

Department of Public Welfare Regulations

129. On September 1, 1973, during the pendency of this lawsuit, the defendants adopted regulations regarding the commitment of juveniles. published in volume 37, Pennsylvania Bulletin (Sept. 1, 1973). These regulations continue to apply to Subclass B, the plaintiffs who are persons with retardation. These regulations *do not apply*

to Subclass A, those persons committed under Section 201, as allegedly mentally ill.

130. The three plaintiffs technically subject to these regulations are totally unable to benefit thereby, as they are unable to understand the rights stated therein or to exercise them. The applicants for admission (two welfare agencies and a parent) have not and will not utilize those provisions to secure these plaintiffs' rights.

Previous Hospitalization

131. Absolutely none of the named plaintiffs in this action have received mental hospitalization prior to the commitments to the institutions in which they are now confined.

Family Disorganization

132. Families seeking commitment of allegedly handicapped children are characterized by severe stress, dislocation and disharmony. The problems of children are a function of intrafamilial problems and exist in a context of a weakened family structure, with conflict overtly expressed.

133. The juvenile behavior which precipitates institutionalization may be provoked by the parents; there are also many cases where the child may be driven to such behavior by the conflicts in the home.

134. Parents will often seek to institutionalize children for improper reasons. This stems from honest mistakes or ignorance or sometimes from malice or ill will. In a significant number of cases, the parental purpose of bringing a child to residential treatment has been to accuse, punish and separate the child from the home. The motivation is not always good.

135. Parents are not particularly good observers of children's behavior and symptoms and, especially in the context of the high feelings that run in situations of

conflict, parents are not reliable sources of factual information about the child and his or her behavior.

136. Parents who bring their children to psychiatrists for care cannot be objective reporters of the behavioral background of the child. They often exaggerate and misinterpret the actions of their children and may often react antagonistically to their children.

Effects of Institutionalization

137. Institutionalization is a severe deprivation of one's liberty and may be extremely harmful, resulting in what one of the state's witnesses at trial called "an emotional deficiency disease." Barton, *Institutional Neurosis* (2d Ed. 1966); Goffman, *Asylums* (1961); Belknap, *Human Problems of State Mental Hospitals* (1956); Stanton and Schwartz, *The Mental Hospital* (1954); Wing and Brown, *Institutionalization and Schizophrenia* (1970); Vail, *Dehumanization and the Institutional Career* (1966).

138. Institutionalization for mental handicap results in severe social stigma, self-stigmatization, employment and license discrimination and liabilities.

139. In a practical sense, institutionalization may make treatment difficult because of the difficulty in involving the family in treatment and the fact that an institutional setting is less likely to be oriented toward family pathology. As one expert testified on the general ill effects of institutions, "We have to be cognizant of the enormous social toll that institutionalization brings."

Reliance on Psychiatrists Would Be Misplaced

140. The mentally retarded should not be in institutions at all.

141. Psychiatrists can and do err and disagree in making diagnoses and recommendations for institutionalization of plaintiffs.

142. As children who are most likely to be institutionalized are in the lower class, the psychiatrists who evaluate them are at a great distance culturally, classwise and geographically from the situation in which the children are living, and thus the psychiatrists misperceive behavior.

143. Psychiatric evaluations for commitment are short and not conducted over a sufficient period of time. Children are often referred for hospitalization without exploration of less restrictive alternatives. Overcrowded clinics may overrecommend institutionalization.

144. In the stress of the admission interview, a juvenile may not present an accurate picture of his or her mental status and may appear in worse condition than is actually the case.

145. There is pressure on the institutional doctor to agree with any referring psychiatrist's recommendation for institutionalization; the needs of the institution will inevitably affect admission decisions of institutional doctors; the information that largely influences the doctor's decision to commit comes from the parents and any referring psychiatrist.

146. Some psychiatrists may start with a presumption that the person before them is mentally disturbed, thereby leading to a skewed interpretation of the picture presented.

147. Improper evaluations may result from countertransference due to which the psychiatrist may become unable to recognize or to explore the patient's conflict in some situations.

148. There is a tremendous conflict of interest created when psychiatrists are permitted to make institutionalization decisions.

149. Present law permits parents to doctor-shop for doctors who will agree to commit their child.

150. The condiserations detailed above apply as well to the mentally retarded.

Factual Basis of Need for Hearing

151. Because of their immaturity and lack of experience, it is even more important that juveniles receive the protection of a hearing than adults. This is especially true of those persons under 14, who are severely limited in their ability to speak for themselves and of the retarded 18 and under.

152. Assistance of counsel is essential and can help treatment of juveniles and can in no significant way hinder such treatment.

153. Hearings would not be unduly traumatic for juveniles and would not interfere with treatment or the parent-child relation. To the contrary, a hearing would encourage more appropriate resolution of problems and would have a positive and beneficial effect on the child.

154. The opportunity for hearings would not discourage people from seeking treatment for juveniles, but would result in agencies and psychiatrists performing more effectively and in the avoidance of the necessity of hearings in many cases.

VIII.
CAUSE OF ACTION

155. By operation of Section 201 and Sections 402 and 403, plaintiffs and their class are detained and incarcerated involuntarily in mental institutions without the right to notice, the right to a hearing or hearings, the right to counsel and, if indigent, appointment of counsel, the right to present evidence and testimony on their own behalf, the right to subpoena witnesses and documents, the right to confront and cross-examine

witnesses against them and those who wish them to be committed, the right to independent expert examination and assistance, the right to be involuntarily detained only upon the decision of a disinterested and impartial decision-maker, the right to appeal, other procedural safeguards.

156. By operation of the said statutes, and by defendants' action in operating, enforcing and executing the same, plaintiffs and their class are deprived of their life, liberty and property without Due Process of Law in violation of the Fourteenth Amendment to the United States Constitution.

IX.
PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray, on behalf of themselves and all others similarly situated, that this Honorable Court:

1. Continue jurisdiction of this cause, and the already-convened three-judge court, and set this case promptly for an expedited hearing;

2. Determine by order, pursuant to Rule 23(c)(1) that this action be maintained as a class action;

3. Enter a final judgment, pursuant to 28 U.S.C. 2201 and 2202 and Rule 57 of the Federal Rules of Civil Procedure declaring that the challenged statutes are invalid, void and of no effect on the ground that they violate the Fourteenth Amendment to the United States Constitution;

4. Enter preliminary and final injunctions enjoining defendants from enforcing and executing such statutory provisions;

5. Allow plaintiffs and the guardian ad litem their

costs herein and reasonable attorney and guardian ad litem fees;

6. Grant such additional and alternative relief as may be deemed by the Court appropriate, just, proper and equitable.

Respectfully submitted,
David Ferleger, Esquire
2321 Sansom Street
Philadelphia, Pa. 19103
215—735-8409, 567-2828
Attorney and Guardian
ad Litem for Plaintiffs

November 2, 1977

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS .; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Plaintiffs

v.

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, Frank Beal; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Defendants

Civil Action No. 72-2272

ANSWER

First Defense

1. *PARAGRAPH ONE* (1) contains legal conclusions to which *NO RESPONSES* are required. However, if they are deemed factual in nature they are denied.

2. *PARAGRAPH TWO* (2) is *ADMITTED* to the extent that it characterizes the form of the action and the manner in which it is brought; all remaining averments are denied.

3. *PARAGRAPH THREE* (3) is *ADMITTED* to the extent that it avers that the defendants are responsible for the custody of the plaintiffs. The characterization of the custody as "involuntary" is a *LEGAL CONCLUSION* to which *NO RESPONSE* is required. However, if it is deemed factual in nature, it is denied.

4. *PARAGRAPH FOUR* (4) is *ADMITTED.*

5. *PARAGRAPH FIVE* (5) is *ADMITTED* to the extent that it purports to characterize the jurisdictional base of this action.

6. *PARAGRAPH SIX* (6) is *ADMITTED* to the extent that it purports to characterize the jurisdictional base of the action. The remaining averment, that defendants acted under color of state law, constitutes a *LEGAL CONCLUSION* to which no response is required. However, if it is deemed factual in nature, it is *DENIED.*

7. *PARAGRAPH SEVEN* (7) is *ADMITTED* to the extent that it purports to set forth the statutes and Federal Rules authorizing plaintiffs' claims for relief.

8. *PARAGRAPH EIGHT* (8) constitutes a *LEGAL CONCLUSION* to which *NO RESPONSE* is required.

9. *PARAGRAPH NINE* (9) is *ADMITTED* to the extent that it purports to characterize the form of this action.

10. *PARAGRAPH TEN* (10) is *ADMITTED* to the extent that it purports to describe the proposed plaintiff class.

11. *PARAGRAPH ELEVEN* (11) is *DENIED.*

12. *PARAGRAPH TWELVE* (12) is *DENIED.*

13. *PARAGRAPH THIRTEEN* (13) is *ADMITTED* to the extent that it purports to set forth the questions of law and fact involved in this action.

14. *PARAGRAPH FOURTEEN* (14) is *ADMITTED.*

15. *PARAGRAPH FIFTEEN* (15) is *ADMITTED* to the extent that it avers the manner in which the plaintiffs bring this action, all remaining factual averments are *denied*.

16. *PARAGRAPH SIXTEEN* (16) is *ADMITTED*.

17. *PARAGRAPH SEVENTEEN* (17) is *ADMITTED*.

18. *PARAGRAPHS EIGHTEEN* (18) through *THIRTY-FIVE* (35) are *ADMITTED*.

26. (Numbered incorrectly in Complaint) *PARAGRAPH TWENTY-SIX* (26) (page 7 of Complaint) is *ADMITTED* except that it is *DENIED* that the plaintiffs' parents "volunteered" the plaintiffs into Haverford State Hospital.

27. (Numbered incorrectly in Complaint) *PARAGRAPH TWENTY-SEVEN* (27) (page 7 of Complaint) is *ADMITTED*.

28. (Numbered incorrectly in Complaint) *PARAGRAPH TWENTY-EIGHT* (28) (page 7 of Complaint) is *ADMITTED* except that it is *DENIED* that "[a] long the hallway are two bare unfurnished rooms. . . .".

29. (Numbered incorrectly in Complaint) *PARAGRAPH TWENTY-NINE* (29) (page 7 of Complaint) is *ADMITTED*.

30. (Numbered incorrectly in Complaint) *PARAGRAPH THIRTY* (30) (page 8 of Complaint) is *ADMITTED*.

32. (Numbered incorrectly in Complaint). *PARAGRAPH THIRTY-TWO* (32) (page 8 of Complaint) is *DENIED*.

33. (Numbered incorrectly in Complaint) *PARAGRAPH THIRTY-THREE* (33) (page 8 of Complaint) is *DENIED*.

34. (Numbered incorrectly in Complaint) *PARAGRAPH THIRTY-FOUR* (34) (page 8 of Complaint) is *DENIED*.

35. (Numbered incorrectly in Complaint) *PARAGRAPH THIRTY-FIVE* (35) (page 8 of Complaint) is *DENIED*.

36. *PARAGRAPH THIRTY-SIX* (36) is *ADMITTED*.

37. *PARAGRAPH THIRTY-SEVEN* (37) is *ADMITTED*.

38. *PARAGRAPH THIRTY-EIGHT* (38) is *ADMITTED*.

39. *PARAGRAPH THIRTY-NINE* (39) is *ADMITTED*.

40. *PARAGRAPH FORTY* (40) is *ADMITTED* except it is *DENIED* that Kevin's brother is in a foster home.

41. *PARAGRAPH FORTY-ONE* (41) is *DENIED*.

42. *PARAGRAPHS FORTY TWO* (42) and *FORTY-THREE* (43) are *ADMITTED* only to the extent that they accurately summarize certain portions of Kevin S's official records at Haverford State Hospital.

44. *PARAGRAPH FORTY-FOUR* (44) is *ADMITTED*.

45. *PARAGRAPH FORTY-FIVE* (45) is *DENIED* as it is an incomplete and therefore inaccurate reference to certain portions of Kevin S.'s official records at Haverford State Hospital.

46. PARAGRAPH FORTY-SIX (46) is *ADMITTED* to the extent that it avers that the decision to admit Kevin S. to Haverford was made on July 13, 1977, and that an admission date of July 18, 1977 was established. All remaining averments are *DENIED*.

47. *PARAGRAPH FORTY-SEVEN* (47) is *ADMITTED*.

48. *PARAGRAPH FORTY-EIGHT* (48) is *DENIED* as being incomplete and therefore inaccurate.

49. *PARAGRAPH FORTY-NINE* (49) is *DENIED.*

50. *PARAGRAPH FIFTY* (50) is *DENIED.*

51. *PARAGRAPH FIFTY-ONE* (51) is *DENIED.*

52. *PARAGRAPH FIFTY-TWO* (52) is *ADMITTED* only to the extent that it accurately summarizes certain portions of Richard S.'s official records at Haverford State Hospital.

53. *PARAGRAPH FIFTY-THREE* (53) is *DENIED.*

54.-55. *PARAGRAPHS FIFTY-FOUR* (54) and *FIFTY-FIVE* (55) are *ADMITTED.*

56. *PARAGRAPH FIFTY-SIX* (56) is *DENIED* as being incomplete and therefore inaccurate.

57.-58. *PARAGRAPHS FIFTY-SEVEN* (57) and *FIFTY-EIGHT* (58) are *DENIED.*

59. *PARAGRAPH FIFTY-NINE* (59) is *ADMITTED.*

60. *PARAGRAPH SIXTY* (60) is *DENIED.*

61.-62. *PARAGRAPHS SIXTY-ONE* (61) and *SIXTY-TWO* (62) are *ADMITTED.*

63. *PARAGRAPH SIXTY-THREE* (63) is *DENIED.*

64. *PARAGRAPH SIXTY-FOUR* (64) is *ADMITTED* only to the extent that it accurately summarizes certain portions of Richard S.'s official records at Haverford State Hospital.

65. *PARAGRAPH SIXTY-FIVE* (65) is *ADMITTED* except that it is *DENIED* that Edward B.'s psychiatrist is "also a full-time psychiatrist in another unit at Haverford State Hospital".

66.-67. *PARAGRAPH SIXTY-SIX* (66) and *SIXTY-SEVEN* (67) are *DENIED* as incomplete and therefore inaccurate summaries of certain portions of Edward B.'s official records at Haverford State Hospital.

68.-69. *PARAGRAPHS SIXTY-EIGHT* (68) and *SIXTY-NINE* (69) are *ADMITTED.*

70. *PARAGRAPH SEVENTY* (70) is *DENIED* as being incomplete and therefore inaccurate.

71. *PARAGRAPH SEVENTY-ONE* (71) is *DENIED* except that it is *ADMITTED* that paragraphs 84-86 refer to this plaintiff.

72. *PARAGRAPH SEVENTY-TWO* (72) is *ADMITTED* except that it is *DENIED* that Raymond C. was committed by his father to Haverford State Hospital.

73. *PARAGRAPH SEVENTY-THREE* (73) is *ADMITTED.*

74. *PARAGRAPH SEVENTY-FOUR* (74) is *DENIED.*

75.-76. *PARAGRAPHS SEVENTY-FIVE* (75) and *SEVENTY-SIX* (76) are *ADMITTED.*

77. *PARAGRAPH SEVENTY-SEVEN* (77) is *DENIED.*

78.-80. *PARAGRAPHS SEVENTY-EIGHT* (78) through *EIGHTY* (80) are *ADMITTED.*

81. *PARAGRAPH EIGHTY-ONE* (81) is *DENIED* as being incomplete and therefore inaccurate.

82. *PARAGRAPH EIGHTY-TWO* (82) is *ADMITTED* only to the extent that it accurately summarizes certain portions of William B.'s official records at Haverford State Hospital.

83. *PARAGRAPH EIGHTY-THREE* (83) is *DENIED* in that the defendants are without knowledge or information sufficient to form a belief as to the truth of the averments contained therein.

84.-85. *PARAGRAPHS EIGHTY-FOUR* (84) and *EIGHTY-FIVE* (85) are *DENIED.*

86.-87. *PARAGRAPHS EIGHTY-SIX* (86) and *EIGHTY-SEVEN* (87) are *ADMITTED.*

88. *PARAGRAPH EIGHTY-EIGHT* (88) is *DENIED.*

89.-90. *PARAGRAPHS EIGHTY-NINE* (89) and *NINETY* (90) are *ADMITTED* only to the extent that they accurately summarize certain portions of Francis B.'s official records at Haverford State Hospital.

91. *PARAGRAPH NINETY-ONE* (91) is *DENIED.*

92.-93. *PARAGRAPHS NINETY-TWO* (92) and *NINETY-THREE* (93) are *ADMITTED.*

94. *PARAGRAPH NINETY-FOUR* (94) is *DENIED* as being incomplete and therefore inaccurate.

95. *PARAGRAPH NINETY-FIVE* (95) is *ADMITTED.*

96.-97. *PARAGRAPHS NINETY-SIX* (96) and *NINETY-SEVEN* (97) are *ADMITTED* only to the extent that they accurately summarize certain portions of Thomas W.'s official records at Haverford State Hospital.

98. *PARAGRAPH NINETY-EIGHT* (98) is *ADMITTED.*

99. *PARAGRAPH NINETY-NINE* (99) is *DENIED.*

100. *PARAGRAPH ONE HUNDRED* (100) is *DENIED.*

101. *PARAGRAPH ONE HUNDRED AND ONE* (101) is *DENIED* except that it is *ADMITTED* that Pennhurst State School and Hospital is located in a rural area of Pennsylvania near Valley Forge, and that it originated in the first decade of this century and is currently unaccredited by the Joint Commission on Accreditation of Hospitals.

102. *PARAGRAPH ONE HUNDRED AND TWO* (102) is *ADMITTED* to the extent that it avers that Polk

State School and Hospital is located in the rural community of Polk, Pennsylvania, approximately 80 miles from Pittsburgh and originated in 1897. All remaining averments are *DENIED.*

103.-116. *PARAGRAPHS ONE HUNDRED AND THREE* (103) through *ONE HUNDRED AND SIXTEEN* (116) are *ADMITTED* only to the extent that they accurately summarize certain portions of the specified plaintiffs' official records at Polk State School and Hospital.

117. *PARAGRAPH ONE HUNDRED AND SEVENTEEN* (117) is *ADMITTED* only to the extent that it accurately summarizes certain portions of George S.'s official records at Pennhurst State School and Hospital except that it is denied that Catholic Social Services was granted a "commitment to Pennhurst for a short-term period of 90 days."

118. *PARAGRAPH ONE HUNDRED AND EIGHTEEN* (118) is *DENIED.*

119.-120. *PARAGRAPHS ONE HUNDRED AND NINETEEN* (119) and *ONE HUNDRED AND TWENTY* (120) are *DENIED.*

122.-129. *PARAGRAPHS ONE HUNDRED AND TWENTY-TWO* (122) through *ONE HUNDRED AND TWENTY-NINE* (129) constitute legal conclusions and therefore require *NO RESPONSES.*

130. *PARAGRAPH ONE HUNDRED AND THIRTY* (130) is *DENIED.*

131. *PARAGRAPH ONE HUNDRED AND THIRTY-ONE* (131) is *ADMITTED.*

132.-156. *PARAGRAPHS ONE HUNDRED AND THIRTY-TWO* (132) through *ONE HUNDRED AND FIFTY-SIX* (156) constitute legal conclusions and therefore require *NO RESPONSE*, if however, they should be deemed factual in nature, they are *DENIED.*

Second Defense

Plaintiffs' claims must be dismissed inasmuch as there is not sufficient "state action" to implicate the Due Process Clause of the Fourteenth Amendment.

Third Defense

Plaintiffs have failed to state a claim for which relief may be granted.

Fourth Defense

This Court lacks jurisdiction over the subject matter of this action.

Fifth Defense

The classes proposed by plaintiff should not be allowed in that juveniles who have been admitted by public welfare cannot adequately represent those unnamed juveniles who have been admitted by their parent or parents.

Sixth Defense

This case should not be maintained as an action against a class of defendants.

Seventh Defense

Plaintiffs have failed to exhaust adequate statutory remedies available to them under state law.

WHEREFORE, defendants request that the complaint be dismissed and that judgment be entered in their favor.

NORMAN J. WATKINS
Deputy Attorney General
ROBERT B. HOFFMAN
Assistant Attorney General

J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation
ROBERT P. KANE
Attorney General

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

INSTITUTIONALIZED JUVENILES, et al.,
Plaintiffs

v.

SECRETARY OF PUBLIC WELFARE, et al.,
Defendants

C. A. No. 72-2272

CERTIFICATE OF SERVICE

AND NOW, this 28th day of November, 1977, I, Norman J. Watkins, Deputy Attorney General for the Commonwealth of Pennsylvania, attorney for defendants, hereby certify that on Monday, November 28, 1977, I served the Answer by depositing said document in the United States Mail, postage prepaid, in Harrisburg, Pennsylvania, addressed to:

David Ferleger, Esquire
2321 Sansom Street
Philadelphia, PA 19103

NORMAN J. WATKINS
Deputy Attorney General

COMPLAINT—MAY 25, 1978

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S.; by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated

v. Plaintiffs

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated

Defendents

CIVIL ACTION NO. 72-2272

OPINION AND ORDER

Before Honorable John J. Gibbons, Circuit Judge and Honorable Daniel H. Huyett, 3rd and Honorable Raymond J. Broderick, District Judges

HUYETT, J. MAY 25, 1978

I. *Introduction*

In 1975, this Court convened as a three-judge federal court pursuant to 28 U.S.C. § 2281[1] held that certain

[1] 28 U.S.C. § 2281 (1970) provided that an application for an injunction against the enforcement of a state statute on grounds of unconstitutionality must be heard by a three-judge district court. This provision was repealed on August 12, 1976.

provisions of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (1966 Act) providing for voluntary commitment and admission to mental health facilities were unconstitutional.[2] *Bartley v. Kremens,* 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded* 431 U.S. 119 (1977). We concluded that these provisions

[2] Sections 402 and 403 of the 1966 Act provide in part:

Section 402. Voluntary admission; application, examination and acceptance; duration of admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application has been made under the provisions of Section 402 (a) (2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of Section 402 (a) (2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

Section 403. Voluntary commitment; application, examination and acceptance; duration of commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in

failed to provide juveniles committed to mental health facilities with specific procedural rights guaranteed by the Fourteenth Amendment to the Constitution which could not be waived by parents, guardians, or persons standing *in loco parentis.*

The Surpeme Court vacated and remanded this case for further consideration in view of the passage by the Pennsylvania Legislature of the Mental Health Procedures Act of 1976 (1976 Act). 50 P.S. §§ 7101-7503 (Supp. 1977-78). The passage of the 1976 Act mooted the claims of the named plaintiffs[3] and, in addition, created distinctions, at least with respect to the governing statutory enactments, between mentally retarded and mentally ill juveniles. It was the Supreme Court's opinion that, in view of these new statutory distinctions, the class action originally approved no longer met the requirements of Fed.R.Civ.P. 23(a). The Supreme Court therefore remanded "for consideration of the class definition, exclusion of those whose claims are moot, and substitution of class representatives with live claims." 431 U.S. at 135.

II. *Statutory Scheme*

We first consider the contours of the statutory scheme governing voluntary admissions and commitments of juveniles. A description of the statutory scheme is important in order to structure properly the subclasses to be maintained pursuant to Rule 23. Furthermore, a full understanding of the statutes is necessary to our determination of whether they satisfy the requirements of procedural due process.

need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

[3] Under the 1976 Act, juveniles age fourteen and older are given essentially the same rights as are given to adults. The named plaintiffs in the original suit were all age fourteen or older; thus, they no longer had a live claim following the passage of the 1976 Act. *See Kremens v. Bartley,* 431 U.S. 119, 126-27 (1977).

A. *The Mental Health Procedures Act of 1976 (1976 Act)*

The 1976 Act repeals the provisions of the 1966 Act except as they relate to mentally retarded persons. Article II of the 1976 Act articulates the procedures for voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" includes all treatment that mandates full or part-time residence in a mental health facility.[4] Section 201 provides that "a parent, guardian, or person standing in loco parentis to a child less than 14 years of age" may apply for voluntary examination and treatment, and by so doing shall be deemed to act on behalf of the child.[5] Once a juvenile is accepted for voluntary examination

[4] Section 103 of the 1976 Act provides as follows:

This act establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" shall include all treatment that requires full or part-time residence in a facility. For the purpose of this act, a "facility" means any mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, whether as outpatients or inpatients.

50 P.S. § 7103 (Supp. 1977-78).

[5] Section 201 of the Act provides as follows:

Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. *A parent, guardian, or*

and treatment the 1976 Act requires that "an individualized treatment plan [be] formulated by a treatment team" within seventy-two hours.[6] The treatment plan must state whether inpatient treatment is necessary and, if so, the reasons for that conclusion.

Section 206 of the 1976 Act sets forth the procedures for withdrawal from voluntary inpatient treatment.[7] Where the person committed is under the age of fourteen,

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person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

50 P.S. § 7210 (Supp. 1977-78) (emphasis added).

[6] Section 20 of the Act provides as follows:

Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment plan shall be formulated by a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

50 P.S. § 7205 (Supp. 1977-78).

[7] Section 206 of the Act provides as follows:

(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203, he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may affect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party

his parent, legal guardian or person standing *in loco parentis* may obtain his release. In addition, "any responsible party" who believes that it would be in the best interests of the juvenile to be withdrawn from inpatient treatment may petition the Juvenile Division of the court of common pleas of the county in which the juvenile resides and request withdrawal or modification of treatment. Then the court must appoint counsel for the child and schedule a hearing within ten days to determine "what inpatient treatment, if any, is in the minor's best interest." 50 P.S. § 7206(b).

B. *Mental Health and Mental Retardation Act of 1966 (1966 Act)*

The 1966 Act was the focus of the original *Bartley* decision in which this Court declared sections 402 and 403 of that Act to be unconstitutional.[8] Following the

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may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or his designate.

50 P.S. § 7206 (Supp. 1977-78).

[8] For the text of section 402 and 403 of the 1966 Act, *see* note 2 *supra*.

passage of the 1976 Act, only mentally retarded juveniles remain within the ambit of the 1966 Act. Sections 402 and 403 provide, in brief, that mentally retarded juveniles age eighteen or younger may be admitted or committed[9] to a mental health facility upon the application of a parent, guardian, or person standing *in loco parentis*, and may withdraw only with the consent of the admitting party or his successor.

C. *1973 Regulations*

The 1973 Regulations, promulgated by the Secretary of Public Welfare under the provisions of the 1966 Act, augment the procedural rights given to mentally retarded

[9] As the Supreme Court noted, 431 U.S. at 124 n. 4, neither party has read the statute as containing a distinction between juveniles who are *admitted* voluntarily under section 402 and those who are *committed* voluntarily under section 403.

[10] The 1973 regulations provide in part:

1. All juveniles aged 18 and younger to be admitted to an Institution must be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist;
2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;
3. The Director of the Institution or his delegate, shall have conducted an independent examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile;
4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;
5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached);
6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director, or his delegate, shall notify the Public Defender's Office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two-day period, the juvenile shall remain institutionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director, or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service Unit to file a 406 proceeding within two days after failure to locate the applicant;
7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile;
8. If the staff member of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification.

juveniles by the 1966 Act.[11] Portions of the regulations apply to all juveniles aged eighteen and younger, such as the requirement that juveniles admitted to a mental health institution be referred by a mental health professional, pediatrician, general physician, or psychologist; that this referral include a psychiatric, medical or psychological evaluation stating specifically the reasons

[11] The parties have stipulated that the 1973 Regulations presently apply only to juveniles committed as mentally retarded under the 1966 Act. Supplementary Exhibit No. 13, Stipulation No. 38.

why the juvenile requires institutional care;[12] and that the Director of the Institution conduct an independent examination of the juvenile prior to admission.

Additional rights are available to mentally retarded juveniles thirteen years of age or older. These juveniles receive written notification explaining their rights and furnishing them with the number of counsel whom they may call for representation. If a juvenile age thirteen or older objects to remaining at the institution, a commitment hearing must be held pursuant to the procedures provided for involuntary commitment.[13] We note here, as we did in the original *Bartley* opinion, that the regulations designate no time by which a post-commitment hearing must be held. 402 F. Supp. at n. 5.

In sum, there are two completely distinct statutory schemes which are under attack in this lawsuit; one relating to the mentally retarded (1966 Act as modified by the 1973 Regulations) and one relating to the mentally ill (1976 Act). Furthermore, with respect to mentally retarded juveniles, older juveniles are given some rights not accorded the younger juveniles.

III. *Named Plaintiffs*

There are twelve named plaintiffs in this lawsuit. Nine are mentally ill juveniles, age thirteen or younger, who were committed to mental health institutions pursuant to the 1976 Act.[14] The remaining named plaintiffs

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[12] *But see* note 55 *supra.*

[13] The procedures for emergency commitment and civil court commitment of mentally retarded juveniles are contained in sections 405 and 406 of the 1966 Act. 50 P.S. §§ 4405 and 4406. These sections are not challenged in this lawsuit.

[14] Four of the mentally ill juveniles have been discharged from Haverford State Hospital since the filing of the amended complaint. At the hearing held March 31, 1978, counsel for the Commonwealth moved for the dismissal of the claims of these plaintiffs on mootness grounds. However, we believe that these claims are not moot. *See Souder v. McGuire,* 423 F. Supp. 830 (M.D. Pa. 1976); *Meisel v. Kremens,* 405 F. Supp. 1253, n. 2 (E.D. Pa. 1975). These plaintiffs retain an interest in receiving declaratory relief, since the possibility remains that they could at any time be recommitted to a mental health facility under the challenged statutes.

are mentally retarded juveniles, age fourteen or older, institutionalized under the 1966 Act and the 1973 Regulations.[15] .

Plaintiff Kevin S., age twelve, was admitted to Haverford State Hospital (Haverford) on July 18, 1977, pursuant to section 201 of the 1976 Act. Kevin's medical records reveal that his mother, who is separated from his father, has a history of serious mental illness, including incidents of hospitalization. Consequently, much of Kevin's youth has been spent in foster homes.

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[15] The named plaintiffs' medical records were offered into evidence at the hearing. Each plaintiff's records are divided into two portions: Part A consists of pre-admission background information, and Part B contains records from and including the actual admission note through the first staff conference. There was no objection to Part B, and those portions of each child's records were admitted into evidence. However, Part A was objected to by the plaintiffs on relevance grounds. Since there was no showing that these records were in the hands of the admitting officials and used by them at the time of the admissions, plaintiffs objected to the relevance of using these records to demonstrate that the defendant institutions engaged in a complete evaluative process prior to the decision to admit. We took the issue of the admissibility of these records under advisement.

Defendants subsequently submitted with their Supplemental Brief affidavits confirming the fact that virtually all of the information was received by the admitting facilities prior to admission. However, there still is little evidence showing in what way, if at all, these records were used during the admissions process. Plaintiffs have suggested that the material be admitted for the limited purpose of providing information on the social and family backgrounds of the named plaintiffs. After examining these records carefully and considering the memoranda submitted by counsel, we believe that Part A of each of the medical records is relevant to issues in this case and admit those portions into evidence.

Prior to his commitment to Haverford, Kevin came to the attention of school authorities because of his inappropriate behavior, such as "making weird noises, refusing to do work, and talking back to teachers." A consulting school psychiatrist diagnosed Kevin as a "disturbed child" and recommended placement in Haverford. Kevin's psychological evaluation, performed after his admission to Haverford, describes him as a "very needy, very angry boy" who was "not currently seen as psychotic, although there is a tendency toward projection and a lack of controls where anxious." His Admission Note, also prepared after his admission, gives as the "reason for admission:" "Difficulties adjusting to school and family (mother). Exhibited bizarre behavior in school that has included making inappropriate sounds and laughing inappropriately." Kevin's psychological history concludes, "It is felt that much of Kevin's problems come from living with a schizophrenic mother and having a very unstable and abused early life."

Richard S., age thirteen, was committed to Haverford by the county child care agency on June 6, 1976 pursuant to section 201 of the 1976 Act. Richard has spent almost all of his life in foster homes and residential homes for difficult children, with the exception of a two-year period between the ages of two and four. His Admission Note for Haverford states, as a reason for admission: "Inability to adjust to an open setting. History of self harm and running away."

Plaintiff James Paul M., age eight, was admitted to Haverford on October 17, 1977, under section 201 of the 1976 Act. His mother had died approximately one year before his admission to Haverford. The stated "reason for admission" to Haverford was "uncontrollable behavior" and "learning disability."

Plaintiff Raymond C., age thirteen, was admitted to Haverford on September 28, 1977, purusant to section 201 of the 1976 Act. Raymond was admitted initially for purposes of "evaluation." The reason given for his admission was "History of uncooperative disruptive and aggressive behavior including run [sic] away from school. Problems in community with stealing and destroying property. Has a learning and hearing problem."

William B., age nine, was committed to Haverford by his father pursuant to section 201 of the 1976 Act on September 21, 1977. For about two years prior to his commitment, William had been living with his natural father, stepmother, and two stepbrothers. The stated reason for his hospitalization was William's "uncontrollable behavior; preoccupied with matches, set a rug on fire, turned the gas burners on in the house, throws things out the window."

Twelve year old Edward B. was committed to Haverford on May 9, 1977 pursuant to section 201 of the 1976 Act. He has subsequently been discharged from Haverford. Hospital records show that Edward was not informed that he was to be admitted to a mental health facility prior to his admission date, but rather was told that his parents were taking him to a new school. He was extremely upset by the admission process, expressing fears about being in a hospital with "crazies" and being confined "like a prisoner." The stated reason for his admission was that Edward was "Hyperactive with poor behavioral control; threatens to hurt himself; feels depressed."

Plaintiff Francis B., age ten, was originally admitted to Haverford pursuant to section 403 of the 1966 Act on August 16, 1976. Subsequently, on September 7, 1976, Francis' father executed a form committing Francis to inpatient treatment pursuant to section 201 of the 1976 Act. While no "reason for admission" is given in the Admission Note, the examining physician stated that Francis had "difficulties adjusting to school" and that he has been described as "hyperactive with short atten-

tion span." Francis B. has subsequently been discharged from Haverford.

Plaintiff Maria L., age twelve, was admitted to Haverford on April 25, 1977, pursuant to section 201 of the 1976 Act. The Admission Note states that she was admitted because of "difficulties adjusting to school because of aggressive behavior . . . [and] difficulties adjusting within the family." Maria has subsequently been discharged from Haverford.

Plaintiff Thomas W. is eleven years old. He was originally committed to Haverford under section 302 of the 1976 Act (Involuntary Emergency Examination and Treatment), which was subsequently changed to a section 201 commitment. The stated reason for admission was Thomas' violent behavior. Thomas has since been discharged from Haverford.

The three remaining named plaintiffs are committed to institutions for mentally retarded pursuant to the 1966 Act. Plaintiff Nancy Louise D., age seventeen, was admitted to Polk State School and Hospital (Polk)[16] and is being confined pursuant to the terms of the 1966 Act. She was living in a foster home until institutionalized on May 22, 1968. Nancy Louise is categorized as being moderately retarded.

Plaintiff Gina S., age sixteen, was admitted to Polk on October 20, 1970 by her mother. She is currently being confined under section 402 of the 1966 Act. Gina's medical records state that she is functioning in the moderately retarded range of intelligence.

Plaintiff George S., age fourteen, was admitted to Pennhurst State School and Hospital (Pennhurst) on November 5, 1969, under the voluntary admission provisions of the 1966 Act in response to a request by Catholic Social Services. Prior to his admission to Pennhurst, he had been living in a foster home until his foster mother became unable to care for him. George is classified as being severely retarded.

[16] Nancy Louise D. was admitted to Polk on May 22, 1968. Her application form for admission shows that she was admitted under the authority of the Mental Health Act of 1951, rather than the 1966 Act then in effect.

IV. *The Class*

The Supreme Court cautioned that "careful attention must be paid to the differences between the mentally ill and mentally retarded, and between the young and the very young." 431 U.S. at 135-36. In response, we have painstakingly reviewed the testimony given at trial and considered as well the supplementary evidence submitted to us on remand.[17] On the basis of the record before us, we find as follows.

As the Supreme Court noted, there are major differences between the mentally ill and the mentally retarded. Mental illness is a term which covers a plethora of problems ranging from severe withdrawal and psychosis to emotional problems which are situationally based.[18] Mentally retarded persons, on the other hand, are defined as those with substantial intellectual subnormalities, coupled with impairments in adaptive behavior origi-

[17] The parties stipulated as follows:

> The evidence which was admitted in the initial proceeding, including all testimony, depositions, exhibits, interrogatories, objections and rulings shall be deemed included in the record of these proceedings. Further, for the convenience of the parties and the Court, the printed Appendix, which was used in the Supreme Court, No. 75-1064, with permission of this Court shall be used in these proceedings.

Stipulation of Counsel No. 40, Supplementary Exhibit No. 40.

We accept the Stipulations of Counsel and incorporate them into our findings.

[18] Testimony of J. Feiner, Appendix at 467a, *Kremens v. Bartley*, 431 U.S. 119 (1977) [hereinafter cited as Appendix].

nating in the developmental period.[19] Approximately three percent of the population, or two to three million persons, are classified as mentally retarded. Eighty to eighty-five percent of those are only mildly retarded; however, even those who suffer from a minor impairment are at times institutionalized.[20] Despite these differences between mental illness and mental retardation, the testimony reveals that, with respect to many of the crucial factors which this court must consider in determining procedural due process requirements, there is little difference between the two groups.

First of all, a similar kind of stigma attaches to institutional commitment whether the juvenile is classified as mentally ill or mentally retarded. Experts on mental illness and retardation testified that this stigma is imposed both outwardly, in that juveniles who have been in institutions encounter substantial obstacles in the community,[21] and inwardly, in that the self-image of the juvenile is almost always severely damaged.[22] Mentally retarded children who are institutionalized are often stigmatized as dangerous and aberrant, thus making their subsequent integration into the community even more difficult. Further, these children are deprived of non-handicapped role models and, as a consequence, tend to adopt behavior patterns which are not socially and culturally appropriate. These behavior patterns may continue after a child is released into the community and, in fact, serve to accentuate the existing community stereotype of the mentally retarded.[23]

[19] Deposition of L. Glenn at 11. By contrast, a person age twenty who suffered brain damage as a result of an automobile accident would not be considered mentally retarded. *Id.*

[20] *Id.* at 9.

[21] *Compare*, Testimony of J. Feiner, Appendix at 474a-75a, *with* Deposition of L. Glenn at 25.

[22] *Compare* Testimony of J. Feiner, Appendix at 474a-75a; Testimony of M. Ingall, Appendix at 595a-96a; and Testimony of E. Messinger, Appendix at 621a-22a *with* Deposition of L. Glenn at 25.

Second, both mental illness and mental retardation are conditions which are subject to error in diagnosis and identification. Experts on mental illness in juveniles repeatedly emphasized that the problems of the juvenile are often closely intertwined with mental and emotional problems of other family members. Irrespective of this fact, the juvenile is often the person isolated as having the mental problems.[24]

Errors in identifying mentally retarded juveniles result from different factors. First of all, certain physical characteristics, *e.g.*, Down's Syndrome, have historically been associated with retardation. However, these associations may not necessarily be accurate. Second, certain physical handicaps may cause a person to be mistakenly labelled mentally retarded. An undetected hearing impairment, for example, may prevent a child from performing well on an I.Q. test. A child who lacks normal motor or speech capabilities, who is unable to communicate or behave like other children, may be mistakenly identified as being retarded.[25]

Third, conflicts between the concerns and interests of the parents, and the best interests of the child frequently arise with respect to both mentally ill and mentally retarded children. Experts on mental illness testified that parents often commit their mentally ill children because of pressures in the home related to the child, or because of the parents' inability to cope with the child's problems

[23] Deposition of L. Glenn at 26-27.

[24] Testimony of J. Feiner, Appendix at 467a-72a; Testimony of M. Ingall, Appendix at 588a-90a; Testimony of E. Messinger, Appendix at 616a-17a.

[25] Deposition of L. Glenn at 13A-14.

and lack of awareness of alternatives to institutionalization.[26] Similarly, parents of mentally retarded children are frequently subject to community pressure to institutionalize their children.[27] Other personal pressures, such as the parents' own emotional difficulties in dealing with the mentally retarded child, as well as the financial problems of providing necessary care, may cause a parent to institutionalize a mentally retarded child although that course is not in the child's best interests.[28] Finally, the parents simply may not be aware of less drastic alternatives to institutionalization.[29] Because of these potential conflicts between the parent and child, experts who testified on behalf of both mentally ill and mentally retarded children were of the opinion that an impartial third party[30] should make the final decision to institutionalize a child, not only for the child's benefit, but also to reduce the trauma and guilt felt by the parents.[31]

Finally, testimony concerning the nature of the deprivation of liberty inherent in institutionalization and the impact of this deprivation upon the individual is similar for both mentally ill and mentally retarded

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[26] Testimony of J. Feiner, Appendix at 472a-73a; Testimony of H. Kandler, Appendix at 553a-54a.

[27] Deposition of L. Glenn at 35-36. For example, parents who have not been exposed to mentally retarded children may become upset when their normal child associates with a mentally retarded child, who the parents perceive as being "different."

[28] *Id.* at 37-42.

[29] *Id.* at 57-58.

[30] The experts did not necessarily agree, however, as to the *identity* of the third party. *Compare e.g.*, Testimony of J. Feiner, Appendix at 478a-79a, *with* Testimony of L. Tashjian, Appendix at 644a-46a, 652a.

[31] Deposition of L. Glenn at 57-58.

children.[32] One expert testified to the "derailment from the usual course of one's life, the dreary regimen even in the most progressive hospitals, the extreme deprivation and limits" which are the effects of institutionalization.[33] Institutions prevent persons from being exposed to normal community experiences and prevent individual growth. With respect to mentally retarded persons, these conditions may be rendered even more acute by the person's inability to protect himself against the dehumanizing effects of institutionalization.[34] Finally, these effects appear to be the same regardless of whether the institution is state-operated or privately-operated; the crucial variable is size.[35]

The ages of the mentally retarded juveniles covered by the 1966 Act range from adolescent to very young. However, we conclude that the same factors hold true irrespective of the child's age. Indeed, the danger of misclassification and the stigma of institutionalization fall more heavily upon the younger child, for whom the decision to institutionalize may effectively foreclose any opportunity to adjust adequately to life in the community. Conversely, there is no evidence to suggest that older mentally retarded juveniles have either a greater or lesser need for procedural due process protection. On the contrary, as with younger juveniles, an older juvenile who is mentally retarded may be functioning under the same disabilities which are pertinent here; that is, he may be unable to read or write, or to under-

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[32] *Compare* Testimony of J. Feiner, Appendix at 474a-75a, and Testimony of E. Messinger, Appendix at 620a-22a *with* Deposition of L. Glenn at 22-24.

[33] Testimony of E. Messinger, Appendix at 621a.

[34] Deposition of L. Glenn at 23-24.

[35] *Id.* at 28. However, the stigma of being labelled mentally ill or mentally retarded remains, regardless of the size of the institution or the actual conditions therein.

stand concepts such as the right to counsel.[36] Therefore we conclude that the need for due process protection and the factors which this Court must consider in determining what process is due, are the same for older and younger mentally retarded juveniles.

V. *Plaintiff Class Action*

Plaintiffs have requested that they be permitted to bring this action on behalf of two classes in accordance with Fed.R.Civ.P. 23(a) and 23(b) (2).[37] One proposed class would consist of juveniles committed as mentally ill and who are under age fourteen; the other class would be juveniles committed as mentally retarded who are

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[36] *Id.* at 64-65.

[37] We approved a defendant class pursuant to Fed.R.Civ.P. 23(a) and 23(b) (2) of "directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare" by Order dated March 28, 1978. *Institutionalized Juveniles v. Secretary of Public Welfare*, C.A. No. 72-2272 (E.D. Pa., March 28, 1978). The defendant class representatives are directors of three state-owned and operated facilities and the Secretary of Public Welfare.

> The parties have stipulated as follows:
>
> All mental health and mental retardation facilities in Pennsylvania which are not state-owned and operated must be licensed and/or approved by the Department of Public Welfare. As part of the approval/licensing, such facilities have been required and are required to utilize and act in conformity with the commitment and admission procedures in both the 1966 Act and the 1976 Act.

Stipulation of Counsel No. 37, Supplementary Exhibit No. 13.

This stipulation serves to buttress our conclusion that there is no conflict between defendant class members because "the challenged statutes and regulations are applicable to all of Pennsylvania's mental health institutions, whether state-owned and operated, or privately-owned." *Institutionalized Juveniles v. Secretary of Public Welfare*, *supra*.

This stipulation also serves to distinguish the case before us

age eighteen or younger. Mindful of the Supreme Court's instructions that we "'stop, look, and listen' before certifying a class in order to adjudicate constitutional claims," we proceed to determine if these proposed classes may be properly maintained.

A. *Mentally Ill Juveniles Under Age Fourteen*

One proposed class consists of all juveniles under the age of fourteen who are subject to inpatient treatment under Article II of the 1976 Act. We conclude that the class meets the requirements of Rule 23.

This class consists of approximately 360 members[38] which is sufficient to meet the numerosity requirements of Rule 23(a).

The question of law common to all class members is the facial validity of those provisions of Article II of the 1976 Act which relate to the voluntary commitment of mentally ill juveniles under the age of fourteen.

Rule 23(a) requires that the claims of the repre-

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from *In Re John S.*, 135 Cal. Rptr. 893 (Ct. App. 1977), where the court held that there was no state action present in a parent's decision to admit their minor child to a private mental hospital. The *John S.* court specifically held that the state "does not control either admissions or treatment policies of the private hospital to which [the] minor was admitted." *Id.* at 901. Therefore, since the parents had not invoked the aid of a state statute in committing their child to a private mental hospital, the state was in no way a party to the parental decision. *Id.* We believe that the situation in Pennsylvania, as reflected by this Stipulation of Counsel, mandates a different conclusion. Since the state actively regulates the admissions procedures of all mental health facilities within the state as part of its licensing power, children who are "voluntarily" admitted to privately-owned facilities are confined pursuant to state law.

[38] See Exhibits A and B to Stipulation of Counsel, Supplementary Exhibit No. 13 (Defendants' Answers to Plaintiffs' Interrogatories).

sentative parties be "typical" and that those parties adequately represent the interests of absent class members. While it has been noted that there is difficulty in distinguishing between the "typicality" and "adequacy" requirements, those two criteria may be taken in concert as requiring that (1) the named plaintiffs be members of the class; (2) the named plaintiffs have no interests antagonistic to those of absent class members; and (3) the named plaintiffs' attorney be qualified, experienced and generally able to conduct the proposed litigation.[39] *See Wetzel v. Liberty Mutual Insurance Co.*, 508 F.2d 239 (3d Cir. 1975); *Eisen N. Carlisle & Jacquelin*, 391 F.2d 555 (2d Cir. 1968); 3B J. Moore, Federal Practice ¶23.07[1] (2d ed. 1977).

Nine of the named plaintiffs are juveniles committed as mentallly ill who are under the age of fourteen; thus, they clearly are members of the class. There is no conflict between these plaintiffs and absent class members. Each class member, irrespective of that child's age, is confined under the same statutory provisions alleged to be unconstitutional. Therefore we conclude that the class itself is cohesive and free from conflict, and that the representative plaintiffs, through counsel, will adequately and vigorously represent the interests of absent class members.[40]

Finally, the class meets the requirements of Rule 23(b)(2), since "the party opposing the class has acted

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[39] We have no doubts concerning the caliber of representation provided by plaintiffs' counsel, as evidenced by the high degree of competence displayed by counsel throughout the course of this litigation.

[40] Plaintiffs' counsel was appointed guardian *ad litem* for the class in order to alleviate any potential problem caused by the difficulty of the class representatives, persons confined to mental institutions, to fairly and adequately represent the interests of the class. *See Goldy v. Beal*, 429 F. Supp. 640, 649 (M.D. Pa. 1976) (three-judge court).

or refused to act on grounds generally applicable to the class," thereby making declaratory or injunctive relief with respect to the entire class appropriate. *See Goldy v. Beal*, 429 F. Supp. 640 (M.D. Pa. 1976) (three-judge court). We find, therefore, that this actiom may be maintained as a class action on behalf of all juveniles committed as mentally ill who are under the age of fourteen.

B. *Mentally Retarded Juveniles Age Eighteen Or Younger*

Plaintiffs also seek to maintain this action on behalf of a class of mentally retarded juveniles age eighteen or younger. This entire class is covered by the 1966 Act; however, as noted above, juveniles age thirteen and over are given additional protection by the 1973 Regulations. The Supreme Court expressly posed the question of whether differences between older and younger juveniles might render certification of a class embracing both groups improper. 431 U.S. at 135. Because of our finding that there are no significant differences between older and younger mentally retarded juveniles for due process purposes, and for other reasons stated below, we conclude that the applicable Rule 23 criteria are met.

This class consists of approximately 3,153 member,[41] which is clearly sufficient to meet Rule 23(a)'s numerosity requirement. Of greater concern is the requirement that there be questions of fact and law common to all class members, since mentally retarded juveniles who are thirteen and over are given greater procedural protection pursuant to the 1973 Regulations than younger juveniles. However, the attack mounted here is against the entire statutory scheme, including

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[41] See Exhibits A and B to Stipulation of Counsel, Supplementary Exhibit No. 13 (Defendants' Answers to Plaintiffs' Interrogatories).

both the applicable provisions of the 1966 Act and the 1973 Regulations. We have previously made a finding that, for procedural due process purposes, there are no significant differences between older and younger mentally retarded juveniles. Therefore, if the statutory scheme is unconstitutional with respect to the older juveniles who receive greater protections, then it is *a fortiori* unconstitutional with respect to the younger juveniles who receive far less protection.

The "typicality" and "adequacy of representation" requirements are also met. The named plaintiffs here are all age thirteen or older and are thus given greater protections under the 1973 Regulations than class members under age thirteen. However, all three mentally retarded plaintiffs were admitted to their respective institutions before they reached age thirteen and, therefore, were presumably not accorded the additional procedural safeguards at the date of their admission. Furthermore, we do not believe that the rights accorded to older juveniles following their admission, such as the right to request a hearing on the validity of their confinement, serve to create a conflict between the older and younger juveniles.[42] First of all, we reiterate our conclusion that due process requirements are the same for both groups. Second, we note that, in order for the named plaintiffs to prevail on their claim that the statutory scheme is unconstitutional, it will be necessary for them to prove the unconstitutionality of the statute and regulations as applied to the less protected younger retarded juveniles.[43] Therefore, we conclude that this action is

[42] There is nothing in the record to show whether notice of these additional rights was given to the juveniles at any time after their thirteenth birthday. Indeed, it is unclear from the text of the 1973 Regulations whether they provide that a juvenile who attains the age of thirteen while institutionalized must be given notice of his additional rights at that time. *See* note 10, *supra*.

[43] We do not believe that it is necessary for the class representatives to have interests identical in every respect to all class members in order to adequately represent the class. What is important is that their interests be the same with respect to the rights sought to be asserted. "Whether a party adequately represents a class depends on all the circumstances of the particular case." *Wetzel v. Liberty Mutual Insurance Co.*, 508 F.2d 239 (3d Cir. 1975) (former employees who voluntarily terminate their employment are able to represent adequately a class of presently employed persons, absent a showing of genuinely antagonistic interests.) Where, as here, there is no conflict between the interests of the representative plaintiffs and the absent class members, and the circumstances clearly demonstrate that the representative plaintiffs will vigorously assert the interest of all class members, we believe that the class action is properly maintained.

properly brought on behalf of a class of mentally retarded juveniles age eighteen or younger.

VI. *Discussion*

In our original decision, we concluded that the plaintiffs had a liberty interest, protectible under the Fourteenth Amendment, in not being institutionalized without due process of law. 402 F. Supp. at 1046. Encompassed within this liberty interest is not only protection against physical restraint and confinement, but also protection of the juvenile's "good name, reputation, honor, [and] integrity." *Wisconsin v. Constantineau*, 400 U.S. 433 (1971), *cited in Bartley v. Kremens*, *supra*, 1046 n. 8. The protection of the plaintiffs' reputation interest is implicated because of the stigma attached to institutional commitment, a stigma which "may render civil commitment a more lasting abridgement of personal freedom than imprisonment for a crime." *Id.* at 1046. We reaffirm these conclusions.

We further determined that this liberty interest could not be waived by plaintiffs' parents, guardians, or persons standing *in loco parentis*. *Id.* at 1047. There may be instances where the congruence between the parents' interests and those of the child assure that the

parents will arrive at a decision based upon the best interests of the child.[44] The evidence in this case overwhelmingly demonstrates that, due to the substantial potential for conflict between the interests of the parent and the child, this is not such a situation. *See New York State Association for Retarded Children v. Carey*, 357 F. Supp. 752, 762 (E.D. N.Y. 1973); *cf Horacek v. Exxon*, 357 F. Supp. 71, 74 (D. Neb. 1973).

It has been argued that the parents' determination that institutionalization is the appropriate treatment for a child believed to be mentally ill or retarded is no different from the deicsion to provide any other type of medical treatment. We disagree. Unlike other kinds of medical treatment, a substantial stigma attaches to institutionalization. This stigma coupled with the substantial danger of error in the diagnosis of mental illness and mental retardation, and the greater potential for long-term loss of liberty[45] create a situation substantially different from the treatment of other medical conditions. Furthermore, we perceive little or no parent-child conflict in the decision to give or withhold other kinds of medical treatment since a parents' interests are more likely to be similar to the best interests of the child. Therefore, we reaffirm our holding that parents may not waive the constitutional right of their child not to be deprived of liberty without due process of law.

We then turned to a consideration of what process was due. In responding to plaintiffs' allegation that they were deprived of certain specific procedural rights, we concluded that the juvenile plaintiffs were entitled to

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[44] We do not mean to imply, however, that in such a case parents necessarily would have the right to waive the constitutional rights of their children.

[45] The testimony demonstrated that, with respect to mentally retarded children, the decision to institutionalize is often a long-term or even life decision. Deposition of L. Glenn at 52-53.

> (1) a probable cause hearing within seventy-two (72) hours from the date of their initial detention; (2) a post-commitment hearing within two (2) weeks from the date of their initial detention; (3) written notice,[46] including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment; (4) counsel at all significant stages of the commitment process and if indigent the right to appoint free counsel;[47] (5) be present at all hearings concerning their proposed commitment; (6) a finding by clear and convincing proof that they are in need of institutionalization; (7) the rights to confront and cross-examine witnesses against them, to offer evidence in their own behalf, and to offer testimony of witnesses.[48]

402 F. Supp. at 1053. While we set forth these detailed procedures, we also stated, "Our action is not intended to preempt the state which is free to develop its own

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[46] Because of those cases where notice to the child might be meaningless, we found that, "until some other procedure is established, this notice shall be sent not only to the child but also to the Clerk of the Court with jurisdiction and shall be forwarded to the child's attorney." 402 F. Supp. at n. 19.

[47] It may not always be necessary to appoint a lawyer so long as a substitute procedure adequately protects the child's interests. For example, it may be sufficient to appoint a guardian, trained in the mental health field, who would advocate the child's interests or alternatively, have the power to retain a lawyer to do so. The important point is that the child must have a capable advocate who has the sole responsibility of advancing the child's best interests. However, until alternative procedures are designed which will adequately protect the child's interests, we adhere to our conclusion that counsel is required.

[48] We further noted that "we neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made." 405 F. Supp. at n. 26. Except with respect to the right to notice and counsel, we concluded that "any or all of these rights may be waived by the child and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and

safeguards so long as they are as fully effective as those which we set out." *Id.* at n. 16, *citing Miranda v. Arizona,* 384 U.S. 436 (1966) and *Morrissey v. Brewer,* 408 U.S. 490 (1971). To rephrase Judge Friendly, there is no single correct solution to the problem of safeguarding the interests of the juvenile plaintiffs; "more of one procedural safeguard may justify less of another." Friendly, *Some Kind of Hearing,* 123 U.Pa.L.Rev. 1267, 1302 (1975).

We reaffirm these conclusions, and make the following additions and clarifications. First, we reiterate the need for a hearing in all cases unless there is a valid waiver. The Supreme Court has dictated that, in identifying the specific contents of due process, three factors must be considered: the private interest involved, the risk of erroneous deprivation, and the Government's interest, including any fiscal and administrative burdens that the additional procedures would entail. *Smith v. O.F.F.E.R.,* 431 U.S. 816 (1977); *Mathews v. Eldridge,* 424 U.S. 319 (1976). The juvenile's interest here is weighty, and the risk of erroneous deprivation, as noted earlier, is great.[49] We believe that a hearing would insure that the interests

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upon a finding that the child understands his rights and is competent to waive them." *Id.* We further concluded that, in the case where a child is unable to understand his rights, the attorney may waive these rights, and "the unbiased tribunal may accept the waiver upon a finding that the waiver is appropriate." *Id.*

[49] The Supreme Court recently emphasized the importance of preventing erroneous deprivations of protected rights, stating:

> Procedural due process rules are meant to protect persons not from the deprivation, but from the mistaken or unjustified deprivation of life, liberty, or property. Thus, in deciding what process constitutionally is due in various contexts, the Court repeatedly has emphasized that "procedural due process rules are shaped by the risk of error inherent in the truth-finding process. . . ."

Carey v. Piphus, 46 U.S.L.W. 4224, 4227 (March 21, 1978) (citations omitted).

of the child are clearly represented, that alternatives to institutionalization are fully explored, and that the decision to commit the child is impartially made.[50] *See J.L. v. Parham,* 412 F. Supp. 112 (M.D. Ga. 1976) (three-judge court); *Lynch v. Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974).

Several issues should be considered at the hearing. First, the unbiased tribunal should determine whether, in fact, the child is mentally ill or mentally retarded. If this determination is affirmative, the tribunal should proceed to determine if commitment is necessary, if it will be beneficial to the child, and if it is the least restrictive alternative. *J.L. v. Parham, supra; Halderman v. Pennhurst State School and Hospital,* C.A. No. 74-1343 (E.D. Pa., December 23, 1977). Where the state sanctions the restriction of child's liberty rights, such restriction should intrude upon those rights to the smallest possible degree necessary for the achievement of the purposes of the restriction. *Shelton v. Tucker,* 364 U.S. 479 (1960). *See Halderman v. Pennhurst State School and Hospital, supra,* and cases cited therein. While the tribunal should make findings to support its determination, these findings need not necessarily be made formally. It is crucial, however, that the tribunal make a good faith, independent determination that the above criteria are met before a juvenile is confined.

We reject the argument that a hearing should not be required because it might prove traumatic for the child. First of all, the expert testimony, for the most part, demonstrated that the effects of a hearing on the child and, in many cases, the parent would be beneficial.[51] For example, one expert testified, with respect

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[50] Several experts testified concerning the function that a hearing would serve. *See, e.g.,* Deposition of L. Glenn at 55-59; Testimony of E. Messinger, Appendix at 623a-25a.

[51] Several experts testified that a hearing would serve a thera-

to mentally retarded children, that a hearing would enhance feelings of dignity and self-worth in the child, reduce the guilt feelings of the parents, and reduce interfamilial conflicts, if any exist, over whether the decision to commit the child is correct.[52] Secondly, we note that the attorney representing the child has the option of waiving the child's presence at the hearing if there is a potential for trauma, and the court may accept such waiver where the child's interests are not compromised. Finally, any danger of trauma pales beside the potential severity of the deprivation of liberty suffered by a child needlessly institutionalized. *See Dixon v. Attorney General*, 325 F. Supp. 966 (M.D. Pa. 1971) (three-judge court).

Finally, with respect to the nature of the tribunal, we state only that the tribunal must be neutral and unbiased. It is clear that "an unbiased tribunal is a necessary element in every case where a hearing is required." Friendly, *Some Kind of Hearing*, 123 U.Pa.L.Rev. 1267, 1279 (1975). Whether the tribunal should be judicial or administrative is not a matter best resolved by this Court at this time.[53]

In view of the guidelines set forth above, we turn to the specific provisions attacked here; namely, the 1973 Regulations and the 1976 Act.

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peutic function in some instances, in that the child would thereby be assured that the decision to commit him was made fairly and impartially. Testimony of J. Feiner, Appendix at 483a-84a; Testimony of H. Kandler, Appendix at 544a.

[52] Deposition of L. Glenn at 56-57.

[53] In our initial opinion, we stated, "Until the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearing the present facilities of the Commonwealth court system shall be used for these hearings." 402 F. Supp. at 18.

We have reconsidered this portion of our original opinion and conclude that the more prudent course of action is to permit the Commonwealth to determine what kind of "unbiased tribunal" should conduct these hearings.

a. *1973 Regulations*

As outlined above, these regulations augment the procedures of the 1966 Act, giving certain procedural rights to all juveniles and other additional rights to juveniles age thirteen and over. Since the passage of the 1976 Act, these provisions apply only to those juveniles who are mentally retarded. We conclude that these 1973 Regulations are not in accord with the requirements of due process.

One of the major deficiencies[54] of the 1973 Regulations is the absence of a procedure designed to achieve informed, impartial admissions. Under the Regulations, a juvenile under the age of eighteen may be admitted to an institution upon the referral of either a pediatrician, general physician, or psychologist[55] with the concurrence of the Director of the Institution.[56] The referring pediatrician or general physician may have no knowledge or training whatsoever concerning the problems of mental retardation,[57] while the Director of the Institution, who

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[54] This discussion is not meant to be an exclusive listing of the procedural deficiencies of the 1973 Regulations. To the extent that the Regulations do not fulfill the requirements stated elsewhere in the text, we hold that they are unconstitutional.

[55] Under the 1973 Regulations, a mentally retarded juvenile may be referred to either a "recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency. . . . a pediatrician, or general physician or psychologist."

The Regulations required that referral of mentally ill juveniles, no longer covered under the Regulations, be accompanied by a psychiatric evaluation, stating "with specificity the reasons that the person requires institutional care." However, the 1973 Regulations permit "a medical or psychological evaluation" to accompany the referral of a mentally retarded juvenile. Further, it is not clear whether these "medical or psychological evaluations" must state the reasons for institutionalization "with specificity."

[56] The Regulations require the Director of the Institution to conduct his own independent examination of the juvenile.

[57] Plaintiff's expert on mental retardation testified that, since

has interests different from those of the child, may be placed into a position of conflict in making the decision to commit.[58] There is no assurance what-so-ever that the interests of the child will be weighed in making this decision. Therefore, this procedure does not provide the protections furnished by hearing before an "unbiased tribunal".

As for the additional procedural rights given to children age thirteen and older, we conclude that there are severe deficiencies in these procedures as well. First of

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mental retardation is not a medical problem, physicians typically are not familiar with developments in the delivery of services to mentally retarded persons. Deposition of L. Glenn at 49. Other mental health professionals often make institutional referrals because of the pressures on them to find rapid placement for mentally retarded children. *Id.* at 50-51.

[58] Many of the experts commented on the conflict of interest which faces the Director of a mental institution in this context. *See e.g., id.* at 46; Testimony of E. Messinger, Appendix at 629a-30a. Dr. Messinger summarized these conflicts as follows:

> [P]sychiatrists are people, too, and we are influenced by considerations other than those that are strictly clinical. For example, if I, as director of a state hospital get a letter from a colleague in a community facility, saying that John Doe really needs psychiatric hospitalization and is severely disturbed, even if I felt otherwise from a direct discussion with the patient, I would be in an awkward position if I said, "No, this patient does not require hospitalization." What do I then say to my colleague whose opinion I disagreed with?
>
> Secondly, professionals—psychiatrists who work for institutions, are influenced by the needs of the institution, as well as the needs of the individual patient. If I am the director of and adolescent service and the funding of my unit depends on how fully utilized the unit is, I might be on the side of admitting the adolescent. I am not saying this is done deliberatly, but I think that a decision as complex as hospitalization is influenced by factors within the psychiatrists at a number of different levels and such considerations as bed utilization will play some role.

Id.

all, the mentally retarded child who receives written notice may not be able to read the notice or comprehend the explanation of his rights contained therein. Assuming that the child does understand the notice, however, the burden of commencing the enumerated procedures rests with the juvenile; he must contact counsel or object to the institutionalization. As one of the experts testified, "It's putting an awful lot of burden on young retarded persons to stand up against a big institution." Deposition of L. Glenn, at 67. Once the child protests, there is no set time limit in which a hearing must be held. We believe that, especially in the case of retarded children, who may lack the ability to understand the notice given to them, due process rights are violated in the absence of an automatic post-commitment hearing, to be scheduled within a reasonable time, and the presence of counsel to speak solely for the child's interests.[59] Therefore, we hold that the 1973 Regulations fall short of the minimum due process requirements we outlined above.

b. *1976 Act*

Article II of the 1976 Act, as noted above, specifies certain procedures for the voluntary "inpatient treatment" of mentally ill juveniles who are age thirteen or younger. We believe that these procedures do not meet due process standards.

We will note specifically several of the deficiencies of the 1976 Act. The major deficiency is the absence of a required post-commitment hearing to be held within a reasonable time after commitment and the absence of counsel to advocate the interests of the child.[60]. We

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[59] We in no way imply, however, that the other rights we have enumerated do not also apply.

[60] The Act does provide that "an individualized treatment plan" be formulated by a "treatment team." The Act further states that

believe that these procedural requirements are especially critical where, as here, the rights of very young children may be implicated. These mentally ill children may lack the ability and capacity to speak on their own behalf, as an older juvenile might be able to do, and their interests may be overlooked.[61]

The procedures governing withdrawal from inpatient treatment in no way cure the defects of the statute. Section 206(b) provides that "any responsible party" may petition the Juvenile Division of the Court of Common Pleas for the modification of or withdrawal from treatment, and at that time, a hearing will be held. Thus, again, rather than providing for automatic procedures aimed at protecting against an unconstitutional deprivation of liberty, the statutory scheme places the burden upon a "responsible party" to initiate the procedures to which the juvenile is entitled. This type of statutory scheme is unacceptable.

"A treatment team must be under the direction of either a physician or a licensed clinical psychologist and may include other mental health professions." 50 P.S. § 7106. There is no assurance of the treatment teams' independence from the inpatient facility into which the child is being committed; and, in fact, the medical records of the named plaintiffs in this case appear to demonstrate that the members of the treatment team are employed by or associated in some way with the admitting institution. Therefore, we believe that this portion of the 1976 Act is essentially no different from the similar requirement of the 1972 Regulations that the Director of the Institution examine all juveniles referred to him before admitting them.

[61] One of the experts testified, with respect to mentally ill juveniles

> I think in fact that the need for a hearing in the younger children is greater, because one cannot expect them to understand fully, certainly in legal terms, their dilemma, nor can they be aware of alternative forms of therapy. . . .I think that because younger children are less sophisticated and less knowledgeable, that we have to bend over backwards to protect their rights.

Testimony of E. Messinger, Appendix at 631a.

Accordingly, we declare that the procedures for voluntary commitment of mentally ill and mentally retarded juveniles, as set forth in the 1966 Act, the 1973 Regulations, and the 1976 Act, are unconstitutional on their face and as applied to plaintiffs, and enjoin their enforcement.[62]

We continue to retain jurisdiction over this action, as we have the inherent power to do. This will enable the parties to apply for amendment or modification of the Order if they deem it necessary.[63]

(s) John J. Gibbons
C.J.
(s) Daniel H. Huyett 3rd
D.J.

Honorable Raymond J. Broderick dissents and will file a dissenting opinion.

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[62] The foregoing shall constitute findings of fact and conclusions of law as required by Fed.R.Civ.P. 52(a).

[63] We have issued a detailed Order in compliance with Fed.R. Civ.P. 65(d) and the Supreme Court's decision in Schmidt v. Lessard, 414 U.S. 473 (1974).

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S.; by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated.

v. Plaintiffs

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated

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Defendents

CIVIL ACTION NO. 72-2272

ORDER

NOW, May 25th, 1978, for the reasons set forth in the accompanying Opinion, IT IS ORDERED that judgment is entered in favor of plaintiffs and against defendants. In accordance with Fed.R.Civ.P. 58 and 65(d), we set forth below the terms of the injunctive relief granted.

CLASS ACTION

1. This action is properly maintained as a class action under Fed.R.Civ.P. 23 (b) (2). Two classes are represented by the named plaintiffs:

(a) all juveniles committed as mentally ill to mental health facilities in Pennsylvania who are under the age of fourteen;

(b) all juveniles committed as mentally retarded to mental health facilities in Pennsylvania who are age eighteen or younger.

2. This action is properly maintained as a defendant class action under Fed.R.Civ.P. 23(b) (2). The class represented by the the named defendants includes directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare.

DECLARATION JUDGMENT

3. Section 402(a) (2), section 402(c) and section 403(a) (2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (1966 Act) are declared to be unconstitutional on their face and as applied under the due processs clause of the Fourteenth Amendment to the United States Constitution.

4. Section 201, section 206(b), and, to the extent that it applies to juveniles under the age of 14, section 205 of the Mental Health Procedures Act of 1976 (1976 Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

5. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to require that mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under the age of fourteen receive prior written notcie of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other trained representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing.

Counsel

6. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel or other trained representative for mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under the age of fourteen; or if the child is indigent, the appointment of free counsel or other trained representative.

Presence of Child

7. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to afford to mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under the age of fourteen who are subject to commitment hearings the rights to be present with counsel or other trained representative, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

Standard of Proof

8. These sections of the 1966 Act and the 1976 Act are delcared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a mentally retarded juvenile eighteen years of age or younger or a mentally ill juvenile under age fourteen, find by clear and convincing proof that the juvenile is in need of institutionalization.

Probable Cause Hearing

9. These sections of the 1966 Act and the 1976 Act are declared invalid in that they permit detention of mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under age fourteen for more than seventy-two (72) hours without a hearing

to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provde at a probable cause hearing the rights delineated in paragraphs 5 through 7 above.

Full Commitment Hearing

10. These sections of the 1966 Act and the 1976 Act are declared invalid in that in the event the initial hearing determines the existence of probable cause, they fail to afford to mentally retarded juveniles eighteen years of age or younger or mentally ill juveniles under age fourteen a full hearing on the need for commitment within two years of age or younger or mentally ill juveniles under age fourteen a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 5 through 8 above.

Regulations

11. The regulations promulgated by defendant Secretary of Public Welfare to supplement the 1966 Act, published at 3 Pa.Bull. 1840 (1973 Regulations), are declared invalid and in violence of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all mentally retarded juveniles eighteen years of age or younger the rights delineated in paragraphs 4 through 9 above.

Admissions and Commitments of Plaintiffs

12. It is declared that all mentally retarded juveniles eighteen years of age or younger admitted or committed to mental health or mental retardation facilities in Pennsylvania under the enumerated sections of the 1966 Act are unconstitutionally held and detained.

13. It is declared that all mentally ill juveniles under age fourteen admitted to mental health facilities in Pennsylvania under the enumerated sections of the 1976 Act are unconstitutionally held and detained.

Application for Treatment of Juveniles

14. It is declared that a parent, guardian, or person standing *in loco parentis* may initiate the temporary detention of a mentally retarded juvenile eighteen years of age or younger or a mentally ill juvenile under age fourteen in a mental health or mental retardation facility if the procedures and requirements of our Opinion and Order are fully complied with.

Requirements for Commitment

15. It is declared that all mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under age of fourteen, who have been, are, or may be subject to admisssion or commission to a mental health or mental retardation facility in Pennsylvania are entitled to:

Notice

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other trained representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney.

Counsel

B. Counsel or other trained representative during all significant stages of the commitment process; if the

juvenile is indigent, counsel or other trained representative shall be provided for free.

Presence of Juvenile and Other Hearing Rights

C. Presence of the juvenile at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

Standard of Proof

D. A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

Probable Cause Hearing

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

Full Commitment Hearing

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

Waiver

16. Excepting the rights to notice and to counsel or other trained representative, any or all of the rights delineated in paragraph 15 may be waived by the juvenile, and the neutral tribunal may accept such a waiver upon approval by the juvenile's counsel or other trained representative and upon a finding that the juvenile understands his rights and is competent to waive them. Because there may be situations where the juvenile either does not understand his rights or is not competent to waive them, any or all of these rights, excepting the rights to notice and to counsel or other trained representative, may also be waived by the juvenile's attorney or representative.

and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

INJUNCTIVE RELIEF

17. It is ordered that the operation of section 402(a)(2), section 402(c), and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (1966 Act) is enjoined in that these sections of the 1966 Act are unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any juvenile eighteen years of age or younger under the 1966 Act to any mental health or mental retardation facility unless the juvenile is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearings. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney or other trained representative.

(2) Counsel or other trained representative during all significant stages of the commitment process; if the juvenile is indigent, counsel or other trained representative shall be provided free.

(3) Presence of the juvenile at all commitment

hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and to counsel or other trained representative, any or all of the rights delineated in paragraph 16(a) may be waived by the juvenile, and the neutral tribunal may accept such a waiver upon approval by the juvenile's counsel or other trained representative and upon a finding that the juvenile understands his rights and is competent to waive them. Because there may be situations where the juvenile either does not understand his rights or is not competent to waive them, any or all of these rights, except the rights to notice and to counsel or other trained representative may also be waived by the juvenile's attorney or other representative, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

18. It is ordered that the operation of section 201, section 206(b), and, to the extent that it applies to juveniles under the age of fourteen, section 205 of the Mental Health Procedures Act of 1976 (1976 Act) is enjoined in that these sections are unconstitutional on their face and as applied under the due process clauses of the Fourteenth Amendment of the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those per-

sons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any juvenile under the age of fourteen under the 1976 Act to any mental health or mental retardation facility unless the juvenile is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney or other representative.

(2) Counsel or other trained representative during all significant stages of the commitment process; if the juvenile is indigent, counsel or other representative shall be provided free.

(3) Presence of the juvenile at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and to counsel or other trained representative, any or all of the rights delineated in paragraph 17(A) may be waived by the juvenile, and the neutral tribunal may accept such a waiver upon approval by the juvenile's counsel or other representative and upon a finding that the juvenile understands his rights and is competent to waive them. Because there may be situations where the juvenile either does not understand his rights or is not competent to waive them, any or all of these rights, excepting to notice and to counsel or other trained representative may also be waived by the juvenile's attorney or other representative, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

19. It is further ordered that the defendant Secretary of Public Welfare and its officers, agents, servants, employees, successors, and those persons in active concert, or participation with them are enjoined:

Regulations

A. To promulgate and issue regulations and to publish them within sixty (60) days as immediately effective, requiring that all mental health and mental retardation facilities in Pennsylvania (see 50 P.S. §4102 and §7103 for the definition of "facility") adhere to the Opinion and Order in this action.

Notice of Order

B. To give notice forwith to all state school and mental hospital directors and their delegates and all directors of all other mental health and mental retardation facilities in Pennsylvania of the Opinion and Order in this action.

Procedures for Children Already Admitted or Committed

C. To initiate procedures, commencing immediately, to assure that all juveniles eighteen years of age

or younger already admitted or committed pursuant to §§ 402 and 403 of the 1966 Act and all juveniles under age fourteen committed pursuant to § 201 of the 1976 Act are either discharged or released or recommitted according to the procedures required by our Opinion and Order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and eighty (180) days of the date of this Order, unless an extension is granted by this Court for good cause shown. Notation shall be made upon the medical records of such juveniles that their discharge, release, or recommitment was effected pursuant to the Opinion and Order in this action.

Reports on Implementation

D. To report to this Court within ninety (90) days and again within two hundred and ten (210) days on the steps taken and progress made in the implementation of our Opinion and Order. The two hundred and ten-day report shall describe, for each mental health or mental retardation facility, the number of juveniles released, discharged or recommitted.

(s) John J. Gibbons
C.J.
(s) Daniel H. Huyett 3rd
D.J.

COMPLAINT--MAY 25, 1978

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S.; by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Plaintiffs

v.

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated,

Defendants

Civil Action No. 72-2272

NOTICE OF APPEAL

NOTICE IS HEREBY GIVEN that Commonwealth of Pennsylvania Defendants, Secretary of Public Welfare, Commonwealth of Pennsylvania; John Fong, Director of Haverford State Hospital; Nicholas D'Aluisio, Director of Polk State School and Hospital; and C. Duane Youngberg, Director of Pennhurst State School and Hospital, hereby appeal to the Supreme Court of

the United States, from the Judgment and Final Order entered in this matter on May 25, 1978.

(s) NORMAN J. WATKINS
Deputy Attorney General

Dated: May 25, 1978

J. JUSTIN BLEWITT, JR.
Deputy Attorney General

ROBERT P. KANE
Attorney General

Attorneys for Commonwealth Defendants

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1977

No. 77-

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUSIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; THOMAS W.; WILLIAM B.; FRANCIS B.; MARIA L.; NANCY LOUISE D.; GINA S.; GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

On Appeal from the Judgement of the United States District Court for the Eastern District of Pennsylvania

MEMORANDUM OF APPELLEES

Appellees, by their counsel and guardian ad litem, respectfully submit the following in response to the appellants Jurisdictional Statement:

1. This appeal is from the judgment of the Three-Judge District Court entered pursuant to the opinion and judgment of this Court in Kremens v. Bartley, 431 U.S. 119 (1977).

2. The appellees believe that the decision of the lower court after

remand is correct and should be affirmed.

3. No person may be committed indefinitely to a mental institution, and subjected to the stigma and the risks of institutionalization, without due process procedures, including counsel and a hearing. Involvement of parents or guardians in the commitment of juveniles does not eliminate or alter the need for such procedures. The district court's detailed factual findings and legal conclusions should not be disturbed. There is no conflict among the circuits on these issues; the questions presented by appellants are insubstantial, in the view of appellees.

4. However, realistic consideration of this Court's previous action in Kremens v. Bartley, supra, and in Parham v. J.L., No. 75-1690, indicates that it is extremely unlikely that the present judgment will be summarily affirmed. Appellees therefore set forth below their views on the relationship between the instant case and the Parham case.

5. It is respectfully submitted that the disposition of Parham v. J.L., to be reargued next Term, cannot affect the need for plenary review of this case for the following reasons:

a. In this case, the lower court specified due process procedures; the Parham court mandated no definite procedures.

b. This case involves both the retarded and mentally ill; the Parham case involves only the mentally ill.

c. The defendants in this case include directors of state-owned and state-licensed facilities, all required to act under the challenged state commitment laws; Parham appears to involve only state-owned facilities.

d. At issue in this case is the power of the lower court to provide relief to plaintiff class members presently institutionalized; this issue is absent from Parham.

6. Whether the lower court's judgment in Parham v. J.L. is affirmed or reversed, issues in the present case will remain to be decided. To the extent similar legal questions are raised in both cases, it would be quite appropriate in the interests of justice for this Court to hear and consider the instant case at the time it hears and determines the Parham case.

WHEREFORE, appellees respectfully submit that, should the judgment below not be summarily affirmed, this case should be reheard in connection with the reargument in Parham v. J.L., No. 75-1690.

Respectfully submitted,

DAVID FERLEGER
2321 Sansom Street
Philadelphia, Pa. 19103
215-567-2828

Counsel for Appellees

May 30, 1978

Supreme Court, U. S.
FILED
AUG 2 1978
MICHAEL RODAK, JR., CLERK

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In the Supreme Court of the United States

October Term, 1978
No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

APPEAL DOCKETED MAY 31, 1978
JURISDICTION NOTED JUNE 19, 1978

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley; Steve Gentile; Lesile Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,
Plaintiffs

v.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
Defendants

RELEVANT DOCKET ENTRIES

1972

Nov. 16, Complaint filed.

Nov. 16, Plaintiffs' Memorandum of Law in support of Motion for Class Action and Convening of a Three-Judge Court filed.

Dec. [Illegible,] Defendants' motion to dismiss filed.

1973

Jan. 2, Plaintiffs' first set of interrogatories to Defendants filed.

March 13, Plaintiffs' Motion for class action filed.

June 8, Transcript of 5/10/73 filed.

Aug. 2, Defendants' Memoranda of Law in Support of Defendants' Motion To Dismiss and Defendants' Motion To Oppose Plaintiffs' Motion for a Class Action filed.

Oct. 4, Youth Law Center of San Francisco, California's request for leave to file brief amicus curiae and brief amicus curiae in support of plaintiffs on behalf of Youth Law Center filed.

Dec. 20, Second set of interrogatories to defendants filed.

1974

Jan. 25, Defendants' answers to second set of interrogatories filed.

April 2, ORDER [dated 4-1-74] that argument shall take place before a three-judge Court on 4-16-74 at 10:00 a.m. re: plaintiffs' motion for a class action determination and on defendants' motion to dismiss; briefs of the moving party shall be filed within 8 days from date of this Order, and reply briefs 5 days thereafter, etc. filed. 4-3-74 Entered and copies mailed.

April 16, Argued sur defendants' motions to dismiss, and for class action; Court stated that case may proceed as a single class action. [3-Judge]

April 19, ORDER that hearing and argument shall take place before the three-judge court at such time and place as the court shall designate following the filing of the final pre-hearing Order, by 5-1-74 for plaintiffs' final proposed order, and the holding of the final pre-hearing conference, scheduled for 5-28-74 at 11:00 a.m. in Room 3006, etc. filed. 4-22-74 Entered and copies mailed.

April 29, ORDER that Haverford State Hospital is dropped as a party defendant, and that complaint shall stand amended by said elimination; that this action shall be maintained as a class action under Rule 23 (b) (1) and (2) of FRCP on behalf of the class comprised of all persons 18 years of age or younger who have been, are or may be admitted to mental health facilities in Pa. pursuant to 50 P.S. §§4402 and 4403, etc.; that David Ferleger, Esq. is appointed guardian ad litem for the plaintiffs and their class pursuant to FRCP Rule 17 (c), etc. filed. 4-30-74 Entered and copies mailed.

April 30, ORDER that the Court Order of 4-19-74 [Paper #47] is amended filed. 5-1-74 Entered and copies mailed.

June 6, Answer filed.

July 29, Final Pre-Hearing Order, certificate of service filed.

July 30, Transcript of 4-16-74 re: argument on plaintiffs' motion for a class action determination and on defendants' motion to dismiss filed.

Aug. 21, ORDER granting petition of American Civil Liberties Foundation permitting same to participate

as *amicus curiae* in this cause filed. 8-23-74 Entered and copies mailed.

Aug. 21, ORDER that final hearing and argument shall take place on 9-9-74 at 10:00 a.m., and on 9-11-74 from 9:30 a.m.-1:00 p.m.; that pre-trial briefs are not required, but may be submitted by 9-3-74; that final pre-hearing Order is fully approved, etc. filed. 8-23-74 Entered and copies mailed.

Aug. 23, ORDER [dated 8-22-74] that Pennsylvania Association for Retarded Citizens [PARC], Inc. and National Center for Law and the Handicapped, Inc. are granted leave to participate as *amici curiae* herein filed. 8-26-74 Entered and copies mailed.

Sept. 3, Defendants' Brief, with exhibits in support thereof filed.

Sept. 6, Brief of Amici Curiae, Penna. Association for Retarded Citizens, Inc. and National Center for Law and the Handicapped, Inc. filed.

Sept. 16, Copy of Brief of Amici Curiae, Penna. Association for Retarded Citizens, Inc. and National Center for Law and the Handicapped, Inc. filed.

Sept. 16, Brief of American Civil Liberties Foundation of Pennsylvania, Inc., Amicus Curiae filed.

Sept. 30, Deposition of Dr. Joel S. Feiner, M.D. of 8-21-74 filed.

Oct. 2, Plaintiffs' Trial Brief, with certificate of service filed.

Oct. 7, Brief of *Amicus Curiae* United States of America, with certificate of service filed.

Oct. 7, Transcript of testimony of Evidentiary hearing of 9-9-74 filed.

Oct. 7, Transcript of testimony of Evidentiary hearing of 9-11-74 filed.

Oct. 7, Deposition of Dr. Barbara Armstrong of 3-2-73 filed. [Exhibit P-7]

Oct. 8, Order that Plaintiffs' proposed Findings of Fact and Conclusions of Law be filed on 10-21-74; Defendants' reply be filed within 10 days of receipt of plaintiffs' Proposed Findings of Fact and Conclusions of Law filed. 10-9-74 entered and copies mailed.

Oct. 18, Plaintiffs' proposed findings of fact and conclusions of law, certificate of service filed.

Oct. 30, Transcript of testimony of Evidentiary Hearing of 10-7-74, Third Day filed.

Nov. 1, Defendants' proposed findings of fact and conclusions of law, certificate of service filed.

Nov. 8, ARGUED SUR: Final merits of the case . . . C.A.V.

Nov. 8, ORDER that plaintiffs' request for admission of Exhibits 2 and 3 is DENIED filed. 11-11-74 Entered and copies mailed.

1975

June 25, Order denying plaintiffs' motion for temporary restraining order, etc. filed. 6/26/75 entered and copies mailed.

July 24, *Opinion,* Huyett, J., Gibbons, J. and Broderick, J. finding §§402 and 403 unconstitutional, etc. filed.

July 24, Order that judgment is entered in favor of plaintiffs and against defendants: Counsel for the parties shall confer and submit an appropriate form order consistent with Opinion within 20 days filed. 7/25/75 entered and copies mailed.

Aug. 7, DISSENTING OPINION, Broderick, J., to the opinion of the court of 7/24/75 filed. 8/7/75 entered and copies mailed.

Aug. 22, Defendants' notice of appeal filed. (Certificate of service) (75-2121)

Oct. 17, Defendants' exceptions to proposed order, etc. and certificate of service filed.

Oct. 31, Certified copy of Order from USCA wherein appellants' motion for leave to stay all proceedings until 30 days after the Supreme Court of the U. S. acts in this matter is GRANTED; motion by plaintiffs-appellees to dismiss appeal with memorandum of law in support of motion to dismiss appeal, etc. is DENIED without prejudice, etc. filed.

Nov. 17, ORDER that this action is properly maintained as a class action and that certain sections of the Pennsylvania Mental Health and Mental Retardation Act are declared invalid, etc. filed. 11-18-75 entered and copies mailed.

Nov. 25, Defendants' motion for a stay and certificate of service filed.

Nov. 26, Defendants' notice of appeal to the Supreme Court (Final Order) and certificate of service filed. (75-1064)

Dec. 1, ORDER that defendants' motion to stay is DENIED filed. 12-2-75 entered and copies mailed.

1976

Feb. 4, Certified copy received from the Supreme Court of the U. S. re file of petition for a writ of certiorari on 1-27-76 as #75-1064, etc. filed.

COMPLAINT—NOVEMBER 16, 1972

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Kevin Bartley; Steve Gentile; Leslie Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Haverford State Hospital; Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Defendants

COMPLAINT—CLASS ACTION

I.

PRELIMINARY STATEMENT

---

1. Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief,

and damages, for violations of their civil rights resulting from the operation of certain parts of the Pennsylvania Mental Health and Mental Retardation Act of 1966 which permit the involuntary commitment of persons eighteen years of age or under to mental health facilities on a different basis than other persons and without notice, hearing, right to counsel and other procedural safeguards. The convening of a three judge court is also sought. The statutes are challenged on the grounds that they conflict with the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.

II.

JURISDICTION

---

2. Jurisdiction is conferred upon this court by 28 U.S.C. § 1331 which provides for original federal question jurisdiction. The amount in controversy, exclusive of interest and costs, is greater than $10,000.

3. Jurisdiction is conferred upon this court by 28 U.S.C. § 1343(3) which provides for original jurisdiction in all suits authorized by 42 U.S.C. § 1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States and by federal law. Defendants here act under color of law.

4. Plaintiffs' action for declaratory and injunctive relief, and for damages, is authorized by:

a. 28 U.S.C. 2201, 2202, 2281 and 2284, and by Rules 57 and 65 of the Federal Rules of Civil Pro-

cedure, which relate to declaratory judgments, injunctions and three judge courts.

b. 42 U.S.C. §§ 1983 and 1988, which relate to civil rights actions.

III.

THREE-JUDGE COURT

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5. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 since Plaintiffs seek an injunction to restrain Defendants, a state institution and state officers, from the enforcement, execution and operation of portions of state statutes (50 P.S. §§ 4402(a)(1), 4402(a)(2), 4402(c), 4403(a)(1), 4403(a)(2) and 4403(c)) of state-wide applicability on the ground that said statutes are contrary to the United States Constitution.

IV.

CLASS ACTION

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6. The named Plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

7. The members of the class of Plaintiffs similarly situated are all persons under eighteen years of age who have been, are, or may be admitted or committed to Haverford State Hospital and all other state mental health facilities under the challenged provisions of the state statute.

8. The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical (and the total membership of the class is indeterminate); there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

9. Defendant Jack B. Kremens, Hospital Director of Defendant Haverford State Hospital, is sued as representative of the directors of all mental health facilities in Pennsylvania, all of which are under the authority and supersion and regulation of Defendants Wohlgemuth and Beach. All the allegations in Paragraph 8 above (with the exception of the last clause) are applicable here and are incorporated by reference.

10. The questions of law and fact involved are:

a. Are the representative parties, and their class, admitted or committed involuntarily to Defendant Haverford State Hospital and other mental health facilities pursuant to the challenged statutory provisions?

b. Do Defendants operate, execute and enforce the challenged statutes?

c. Are the challenged statutes contrary to the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution?

V.

PLAINTIFFS

11. Plaintiff Kevin Bartley is a citizen of Pennsylvania, age 16, having been born November 4, 1956.

12. Plaintiff Steve Gentile is a citizen of Pennsylvania, age 18, having been born March 20, 1954.

13. Plaintiff Leslie Levine is a citizen of Pennsylvania, age 15, having been born October 8, 1957.

14. Plaintiff Vicki Mathews is a citizen of Pennsylvania, age 15, having been born September 10, 1957.

15. Plaintiff Mark Weand is a citizen of Pennsylvania, age 15, having been born June 13, 1957.

16. All named Plaintiffs are being held at Defendant Haverford State Hospital against their will having been admitted or committed by Defendants or under their direction pursuant to the challenged sections of the Pennsylvania Mental Health and Mental Retardation Act of 1966. Such admissions and commitments were accomplished without notice, hearing, right to counsel or order of court.

VI.

DEFENDANTS

17. Defendant Haverford State Hospital is a mental health "facility" under Section 102 of the Pennsylvania Mental Health and Mental Retardation Act of 1966.

It receives admissions and commitments of persons, including Plaintiffs and their class, under said act.

18. Defendant Jack B. Kremens is Hospital Director of Defendant Haverford State Hospital and is charged with supervision and administration of the facility. See Sections 102 and 203 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (hereafter the "Act"). It is to Kremens or his delegate that applications for admission, commitment and release must be made. See Sections 402 (b), 403 (b) and 403 (c) of the Act.

19. Defendant Helene Wohlgemuth is the Secretary of Public Welfare of the Commonwealth of Pennsylvania which department has the power and duty to enforce the Act and all regulations necessary and appropriate to the proper accomplishment of the Act and to operate and assign functions to all state facilities. See Sections 201 (2) and 202 (a) of the Act.

20. Defendant William B. Beach, Jr. is the Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania. He has general authority to supervise and regulate mental health facilities within Pennsylvania.

VII.

FACTUAL ALLEGATIONS

Kevin Bartley

21. Plaintiff Kevin Bartley was committed to Haverford State Hospital on November 30, 1971 under Section 403 (a) (2) of the Act.

22. He was committed by his mother although he did not wish to enter the hospital then and does not wish to remain now. Kevin Bartley is critical of many of what he believes are the hospital's shortcomings: e.g., arbitrary regulations, the staff's playing favorites with patients, unnecessary punishments for minor rule infractions, and transfer to locked wards as punishment for mere allegations of wrongdoing, without hearing or proof.

23. Bartley believes that nothing worthwhile is occurring to him inside the hospital and that his time is mostly being wasted. This is true. When he obtains release, he plans to go to school and learn a usable trade.

Steve Gentile

24. Plaintiff Steve Gentile was committed to Haverford State Hospital on August 24, 1971 by his father under Section 403 (a) (2) of the Act.

25. Gentile entered the hospital involuntarily, is being detained there involuntarily and wishes to leave but is restrained from doing so by Defendants and the operation of the challenged portions of the Act.

Leslie Levine

26. Plaintiff Leslie Levine's mother committed her to Haverford State Hospital on October 11, 1972 under Section 403 (a) (2) of the Act.

27. Levine does not wish to remain at the hospital but is restrained from leaving by Defendants and by the operation of the challenged portions of the Act.

28. Levine was committed to the hospital because she does not get along with her mother and sister. Her parents are divorced; her father is remarried and living in Florida. Leslie Levine would like to be with her father; they get along well and, every time she spends some time with him, her behavior is excellent. However, because she is with her mother and sister and does not get along with them, Levine is an involuntary mental hospital patient.

Vicki Mathews

29. Plaintiff Vicki Mathews was committed to Haverford State Hospital on August 9, 1972 by her parents under Section 403 (a) (2) of the Act.

30. She entered the hospital involuntarily.

31. Mathews does not get along well with her parents and has in the past run away from home. If she were considered a "delinquent," and dealt with through the juvenile court process, she could not be institutionalized against her will except after a full hearing, upon order of a court. In fact, as the mental health commitment laws permit, her parents had the choice of avoiding the due process protections afforded juveniles in other contexts and of dealing with her in their own way, thus depriving Mathews of any hearing and committing her to a mental hospital.

32. Because her parents had the financial means, on information and belief, they applied for her discharge from the hospital under Section 403 (c) so that she could be shipped, against her will, to a boarding school in Texas.

Mark Weand

33. Plaintiff Mark Weand was admitted to Haverford State Hospital on June 23, 1972 by his mother under Section 402 (a) (2) of the Act.

34. After another hospital would not admit him because of his age, Weand first entered Haverford for medical reasons because of excess use of drugs. Once at the hospital, his mother was convinced by agents and employees of Defendants to have Weand admitted for psychiatric reasons. Weand did not wish to become a mental patient and repeatedly has informed Defendants' agents and employees of his desire to leave. They have not permitted him to do so.

35. At the hospital, Weand has not been involved with any therapeutic drug programs because he has not been addicted to any drugs.

36. His mother is concerned about him but will not apply for his release except upon the approval of the hospital physicians, employees and agents of Defendants. If Weand were a voluntary patient under Section 402 of the Act and were over eighteen, he would be permitted to leave the hospital "at any time" regardless of the physicians' approval or opinion.

37. The major reason Weand has been hospitalized for the past five months is that the hospital's agents and employees have considered his attitude hostile and aggressive. The basis for this "hostile" and "aggressive" attitude is Weand's belief that he doesn't belong in the mental hospital and Weand's questioning and criticism of the hospital regimen and his treatment there.

The Statutory Scheme

38. Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. § 4402) provides as follows: (Those parts which are challenged as unconstitutional by this Complaint are emphasized by underlining [italics])

Section 402. Voluntary Admission; Application, Examination and Acceptance; Duration of Admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) *Except where application for admission has been made under the provisions of Section 402 (a) (2) and the person admitted is still eighteen years of age or younger*, any person voluntarily admitted shall be free to withdraw at any time. *Where application has been made under the provisions of Section 402 (a) (2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.*

(d) Omitted here.

39. Section 403 of the Act (50 P.S. § 4403) provides as follows. (Those parts which are challenged as unconstitutional by this Complaint are emphasized by underlining [italics])

Section 403. Voluntary Commitment; Application, Examination and Acceptance; Duration of Commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, *or after the applicant or his successor has given notice of intention or desire to remove the detained person.*

(d) Omitted here.

40. The only other provisions for civil commitment to a mental health facility provided by the Act are:

a. Section 404 which permitted commitment of persons upon application of third parties (including parents, guardians, individuals standing in loco parentis, etc.) upon application with certificates of two physicians. Because of its denial of Constitutional Due Process rights, this section has been declared unconstitutional. See Section 404 and *Dixon v. Attorney General of the Commonwealth of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971).

b. Section 405 permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than ten days.

c. Section 406 permits involuntary commitment of persons, regardless of age, upon petition to the state court of common pleas, and after hearing and examination. The respondent to such petition has the right to notice of the hearing, the right to counsel and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

VIII.

FIRST CAUSE OF ACTION

For a First Cause of Action, Plaintiffs reallege Paragraphs 1 through 40 above, which are incorporated herein by reference, and further allege:

41. Voluntary patients over eighteen years of age enter facilities under the Act on their own application and

volition under Section 402 or 403 and may leave and discharge themselves either at any time (Section 402) or upon proper written notice (Section 403). Plaintiffs and their class are denied such entrance and separation from the facility by the challenged portions of these sections of the Act.

42. The statute thus creates two classes of potential and actual "voluntary" admittees, distinguishable only on the basis of age. There is no adequate state justification for this arbitrary classification.

43. A person over eighteen years of age who does not wish to enter a facility may be placed there involuntarily only upon the order of a court pursuant to the procedures, including a petition, notice and hearing, mandated by Section 406 of the Act. A person under eighteen years of age who does not wish to enter a facility may be placed there involuntarily simply upon the application of a parent, guardian or individual standing in loco parentis; no notice or petition is required nor is any sort of hearing or court order provided for.

44. The statute thus creates two classes of potential and actual involuntary admittees and committees, distinguishable only on the basis of age. There is no adequate state justification for this arbitrary classification.

45. The challenged portions of the Act and Defendants' actions in operating, enforcing and executing the same, deny Plaintiffs and their class the equal protection of the laws in violation of the Fourteenth Amendment to the United States Constitution.

IX.

SECOND CAUSE OF ACTION

For a Second Cause of Action, Plaintiffs reallege Paragraphs 1 through 40 above, which are incorporated herein by reference and further allege:

46. By operation of the challenged portions of the Act, Plaintiffs and their class are detained and incarcerated involuntarily in mental hospitals and other facilities without:

a. the right to notice;

b. the right to a hearing;

c. the right to counsel and, if indigent, appointment of counsel;

d. the right to present evidence and testimony on their own behalf;

e. the right to subpoena witnesses and documents;

f. the right to confront and cross-examine witnesses against them and those who wish them to enter a facility;

g. the right to independent expert examination and assistance;

h. the right to be involuntarily detained only upon decision of a disinterested and impartial decision-maker;

i. the right to be involuntarily detained only upon a decision that they are in need of care, treatment or observation, such decision being based on clear and convincing evidence;

j. the right to appeal and review, including provision for assistance of counsel and record and transcript without cost if appellant is unable to pay the cost thereof;

k. other procedural safeguards.

47. By operation of the challenged portions of the Act, and by Defendants' actions in operating, enforcing and executing the same, Plaintiffs and their class are deprived of their life, liberty and property without due process of law in violation of the Fourteenth Amendment to the United States Constitution.

X.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray, on behalf of themselves and all others similarly situated, that this Honorable Court:

1. Assume jurisdiction of this cause, convene a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 to determine this controversy, and set this case promptly for an expedited hearing;

2. Determine by Order, pursuant to Rule 23(c) (1) of the Federal Rules of Civil Procedure, that this action be maintained as a class action;

3. Enter a final judgment, pursuant to 28 U.S.C. §§ 2201 and 2202 and Rule 57 of the Federal Rules of Civil Procedure declaring that the challenged portions of the Pennsylvania Mental Health and Mental Retardation Act of 1966, that is 50 P.S. §§ 4402(a) (1), 4402(a) (2),

4402(c), 4403(a) (1), 4403(a) (2), and 4403 (c) (see paragraphs 38 and 39 above), are invalid, void and of no effect on the grounds that they violate the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution;

4. Enter preliminary and permanent injunctions enjoining Defendants from enforcing and executing such statutory provisions;

5. Award damages to each of the named Plaintiffs in the amount of $15,000 each for unconstitutional deprivation of their rights;

6. Allow Plaintiffs their costs herein and reasonable attorney's fees;

7. Grant such additional and alternative relief as may be deemed by this Court appropriate, just, proper and equitable.

Respectfully submitted,

(s) David Ferleger
David Ferleger
Attorney and Next Friend for Plaintiffs
Mental Patient Civil Liberties Project
121 South 18th Street
Philadelphia, Pa. 19103
(215) 561-4715

On the Brief:

Ronald Soskin
Stan Abramson

Dated November 16, 1972

MOTION TO DISMISS

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

[Title omitted in printing.]

MOTION TO DISMISS

Defendants move that this Honorable Court dismiss the above captioned action on the basis that Plaintiffs have failed to plead an action upon which relief may be granted.

Marx S. Leopold
Assistant Attorney General

December 12, 1972

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted]

FIRST SET OF INTERROGATORIES TO DEFENDANTS

Definitions

As used in the interrogatories below, the following words shall be taken to have the following meanings:

a. "Juvenile (s)"—Persons eighteen years of age or younger.

b. "Facility (ies)"—"Any mental health establishment, hospital, clinic, institution, center, day care center or other organizational unit, or part thereof, which is devoted primarily to the diagnosis, treatment, care, rehabilitation or detention of mentally disabled persons." (As defined in the Mental Health and Mental Retardation Act of 1966).

c. "Act"—The Pennsylvania Mental Health and Mental Retardation Act of 1966.

d. "Director (s)"—"The administrative head of a facility and includes superintendents." (As defined in the Act).

e. "Department"—The Department of Public Welfare.

f. "Adult (s)"—Persons over eighteen years of age.

g. "Civil Commitment"—Commitment to a facility under Section 406 of the Act.

h. "Voluntary Admission"—Admission or commitment to a facility under Section 402 or Section 403 of the Act.

i. "State"—Pennsylvania, often with reference to the state government.

Interrogatories

1. Name all the state facilities, that is, those owned and operated by the state. Also, their addresses.

2. What are the names of all the facilities in Pennsylvania which are privately owned, regulated by the state and the Department, and which admit or commit any persons under the Act? Also, their addresses?

3. What are the policies of the Department with regard to criteria for admission or commitment of juveniles to facilities, that is, what criteria are used?

4. What are the policies of the Department with regard to criteria for admission and commitment of adults to facilities, that is, what criteria are used?

5. What are the policies of Directors with regard to acting upon applications for voluntary admissions of juveniles to facilities, that is, what criteria are used?

6. What are the policies of Directors with regard to acting upon applications for voluntary admissions of adults to facilities, that is, what criteria are used?

7. Identify and describe the nature, custody and location of all memoranda, directives, orders, policies, regulations and other or similar documents issued by the Department or other state authorities or known to Defendants which pertain to the voluntary admission or civil commitment of juveniles to facilities.

8. Identify and describe the nature, custody and location of all memoranda, directives, orders, policies, regulations and other or similar documents issued by the Department or other state authorities or known to Defendants which pertain to voluntary admission or civil commitment of adults to facilities.

9. Name all juveniles presently in all facilities as voluntary admissions and provide the name of the facility each is in.

10. Name all juveniles presently in all facilities as civil commitments and provide the name of the facility each is in.

11. For each juvenile in a facility as a voluntary admission, what is or are the major behaviors or activities upon which such admission was based?

12. For each juvenile in a facility as a civil commitment, what is or are the major behaviors or activities upon which such commitment was based?

13. For each juvenile in a facility as a voluntary admission, what is the name and address of the applicant for admission and identify the relationship of the applicant to the juvenile (e.g., parent, guardian or person *in loco parentis*) ?

14. For each juvenile in a facility as a result of a civil commitment, what is the name and address of the

Petitioner and identify the relationship of the Petitioner to the juvenile?

(s) David Ferleger
David Ferleger
Mental Patient Civil Liberties Project
121 S. 18th Street
Philadelphia, Pa. 19103
Attorney for Plaintiffs

December 22, 1972

Please answer, in accordance with Rule 33, within thirty days.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

[Title omitted in printing.]

MOTION FOR CLASS ACTION

Plaintiffs, by their attorney and next friend, David Ferleger, Esquire, respectfully move this Honorable Court to order that this action be maintained as a class action.

Rule 23(c) provides:

> As soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be so maintained. An order under this subdivision may be conditional, and may be altered or amended before the decision on the merits.

In their *Memorandum of Law in Support of Motion for Class Action and Three-Judge Court,* filed with the Complaint, Plaintiffs detailed the argument on which they here rely at pages 1 through 3 of that memorandum. No

memorandum or motion has been filed in opposition by Defendants, except a motion to dismiss under Rule 12 (b) (6).

Respectfully submitted,
(s) David Ferleger
David Ferleger, Esquire
Mental Patient Civil Liberties Project
121 South 18th Street
Philadelphia, Pa. 19103
Attorney and Next Friend to Plaintiffs

March 13, 1973

[Certificate of Service omitted.]

ORDER

[Caption Omitted]

AND NOW, this 25 day of April, 1973, it is hereby ordered and decreed that:

1. The two affidavits of juveniles at Haverford State Hospital submitted by Plaintiffs on April 12, 1973 to this Court be sealed and impounded until further order of this Court;

2. The parties and their attorneys shall not disclose to others the names of the affiants except with the permission of the Court. The contents, without identifying data, may be disclosed;

3. Defendants, their agents and employees, are enjoined from interfering with the First Amendment rights of affiants and from punishing, disciplining, interrogating or otherwise imposing sanctions on affiants by reason of their affidavits herein.

For the Court:
(s) Thomas A. [Illegible]
J.

[Caption Omitted]

MOTION FOR SEALING OF AFFIDAVITS AND PROTECTION OF AFFIANTS

David Ferleger, attorney for Plaintiffs, respectfully represents that:

1. Attached are two affidavits of juveniles now at Haverford State Hospital pursuant to the challenged portions of the state mental health act. Their parents and various mental health professionals, including the Defendants and their agents, caused their commitment.

2. The affiants would be embarassed and their (and their families') reputation affected adversely by public disclosure of their names and their affidavits.

3. The affiants fear that the Defendants and their employees will take disciplinary or other action against them for their criticisms of their confinement as expressed in these affidavits.

Wherefore, it is respectfully prayed that: 1) these affidavits be sealed and impounded until further order of the Court; 2) the parties and their attorneys be ordered not to disclose the names of the affiants to the public except with the permission of the Court; and 3) the Defendants, their agents and employees be enjoined from interfering with the First Amendment rights of affiants and from punishing, disciplining, interrogating or otherwise imposing sanctions on affiants by reason of their affidavits herein.

Respectfully submitted,
(s) David Ferleger
David Ferleger, Esquire
Mental Patient Civil Liberties Project
121 S. 18th Street
Philadelphia, Pa. 19103

This is to certify that on day of April, 1973, I mailed a copy of the foregoing to Marx Leopold, Esq. and Barry Roth, Esq., Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa.

David Ferleger

[Caption Omitted]

AFFIDAVIT

My name is A . . . M . . . I was transferred to Haverford from the University of Pennsylvania Hospital. My parents brought me here, but I didn't want to come. It was too late, I couldn't do anything about it. I said I didn't want to stay here. The doctor got me to admit that I needed help but I told him that I still didn't want to stay. Like I know some girl that was here a couple of weeks ago, Debbie Geiger, her parents told her they were going to see a doctor—that's how she got here. But if you're under 18, well you know.

When I first got here they pushed me into a room and told me to take off my clothes and put on pajamas. Then they took me up to the fifth floor. I wasn't expecting to be locked up. It really drives you crazy. They didn't explain anything to me—they put you up there and that's it. My mother says if she knew that she wouldn't have put me in here. I was up there 3 or 4 days before I was sent to Building 9.

They threaten you here—that's the really bad part. You do what we say or you go up the hill or something—restrictions. Like me and D . . . D . . .—we'll probably get sent up the hill again cause we didn't go to our half hour of art therapy. D . . . got sent up for five days because he wouldn't take his restrictions. They don't care—they don't care about anything. The evening and late night staff stinks. The only staff that really cares is the day staff.

I got transferred to Building 4 one night. I cut myself on purpose. My hands were bleeding and they said I was going for a tetanus shot. They didn't explain what they were doing or tell you they were taking you up. They should at least have told my parents. I would still be there but my doctor, Dr. Kratsa, got me back the next day. If you get sent up on a Friday and your doctor is only here Tuesday, Wednesday and Thursday, you'll be there till next Tuesday at least. Do you think you can do anything about the restrictions and us getting sent up the hill?

I am presently a patient at Haverford State Hospital. Since a notary public is not available at the hospital and since I am not able to secure release for the purpose of signing before a notary public, I am forced to sign without notarization. I swear that the above statements are true and correct to the best of my knowledge, information and belief and I sign below under pain of perjury.

(s) A . . . M . . .

Signed on this 9th day of April, 1973.

[Caption Omitted]

AFFIDAVIT

My name is D . . . D . . . I am 14 years old and live with my parents at 2624 Sunset Boulevard in Broomall, Pennsylvania.

Before I got here I was on probation for truancy. I broke probation because I was truant again. My parents told me they wanted to have a meeting with me down at Haverford State. My mom said a psychiatrist and a social

worker would be there. This woman at the Media Court House recommended to my parents that they bring me here. They wanted me to come that day but I said no, I wanted to say goodbye to my friends that night. I came the next morning at 7 a.m. I didn't even get to see my probation officer. When I got to the hospital the doctor, Dr. Kratsa, wanted me to go to reform school. My parents kept saying no. They made it sound like if I didn't come here I'd be going to reform school. So I figured it would be a lot better here than reform school. So I said yes. That's how they tricked me.

About the only big complaint I have is the restrictions. That's the only thing that's a matter with this hospital. I was supposed to sit in my alcove for two nights because I didn't do clean-up. I got sent up the hill to the locked building because I wouldn't take my restrictions. I think that's pretty stupid. Why should we be sent up there? We don't belong there with those people. They ought to have a better way of punishing you. I was there for 5 days—I've never been locked up for a length of time like that before. There are people there that bothered me and wanted me to let them do stuff to me, but I don't want to get them in trouble—that's just part of their problem. One guy used to wake me up and pounce on top of me and hit me.

The fourth floor of Building 4 is worse than the fifth floor where I got sent the first time. I had a bad day in Building 9 and I was mixed up and I didn't want to stay there that night, but they wouldn't let me go to Building 4 just for the night. So I broke a window to get sent there. They found phenobarbitol tablets in my room after I broke the window. I got them here at the hospital—a lot of kids in the building did. That's why a lot of us got sent

up here. I had a bowl of grass too that I had from home. My friends used to bring up stuff too. The fourth floor is worse than the fifth. I've been here over a week now. Most of them on this floor want to try stuff with me but I won't let them. One guy gave me all sorts of presents and then he told me what he wanted me to let him do just like the others, but I told him no. I want to get off this floor. I'll never bring any dope in anymore. I like the stuff they're giving me here though—I'm flying. Don't let them change it. I'd rather be on the fifth floor again or in Building 9. I want to be able to go home on the weekends. I'll write a commitment saying I won't do dope anymore. I'd like you to try and help me. I want you to talk to my doctor, Dr. Kratsa, about all of this.

I am presently a patient at Haverford State Hospital. Since a notary public is not available at the hospital and since I am not able to secure release for the purpose of signing before a notary public, I am forced to sign without notarization. I swear that the above statements are true and correct to the best of my knowledge, information and belief and I sign below under pain of perjury.

(s) D . . . D . . .

Signed on this 9th day of April, 1973.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, Steve Gentile, Leslie Levine, Vicki Mathews, Mark Weand, minors, through their next friend, individually, and on behalf of all others similarly situated

vs.

Haverford State Hospital, Jack B. Kremens, et al.

Oral examination before trial by Dr. Barbara Armstrong, at the law office of Mental Patient Civil Liberties Project, David Ferleger, Esquire, 121 South 18th Street, Philadelphia, Pennsylvania, on Friday, March 2, 1973, at 10:00 a.m., before Patricia M. Kosmalski, Approved Reporter.

Present:

David Ferleger, Esq., and Stan Abramson, Esq., Counsel for the Plaintiffs.

Barry A. Roth, Esq., Assistant Attorney General, Counsel for the Defendants.

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(2) (It is stipulated and agreed by and between counsel that sealing, filing, and certification of the

examination before trial be waived, and that all objections, except as to the form of the questions, be reserved to the trial of the cause.)

DR. BARBARA ARMSTRONG, Director of Adolescent Services, Haverford State Hospital, Haverford, Pennsylvania, sworn.

MR. FERLEGER: Dr. Armstrong, do you understand the purpose of this deposition?

THE WITNESS: No.

MR. FERLEGER: The purpose of a deposition, under the Federal Rules of Civil Procedure, under the rules of lawsuits conducted, each side is afforded the opportunity for discovery to find out what potential witnesses may have to say, and to record testimony in case it is needed in the future for court. The deposition can be used in court to contradict or impeach what you say. It can be used in court if it happens that at the time of trial or hearing, you happen to (3) be more than a hundred miles away.

For example, you can't come if you should die before the court hearing. This deposition can be used as your testimony in that case, and under other exceptions and circumstances, it can also be used.

Because it can be used in court and because of the seriousness of the discovery process, you were sworn at the time this deposition was taken. So, you are obliged to tell the truth, as this is a serious kind of thing we are about to begin here today.

THE WITNESS: Yes. I understand.

MR. FERLEGER: Have you read the complaint and memorandum in the Bartley suit?

Mr. Roth, I would appreciate it if you don't shake your head and answer for her.

MR. ROTH: I am not answering.

THE WITNESS: I am not sure. I remember I read the deposition, I guess, in this case, of Dr. Kremens.

MR. FERLEGER: Have you read this paper captioned, "Complaint in Class, More Than In Law, of Class Action"?

(4) MR. ROTH: Do you mind showing me copies? Do you want to state your purpose of this deposition—I imagine, your objective, instead of going into needless impressions or embarrassment?

MR. FERLEGER: My objective is to determine what information Dr. Armstrong might have that would lead to discovery of other relevant material in this lawsuit. Since she is the doctor of a number of named plaintiffs and other members of this class action, I want to talk to her about problems involved. I don't know where you got the idea I have the desire to embarrass or press her.

MR. ROTH: I am concerned that this is going to be a fishing deposition, and I am going to make a motion to discontinue the deposition.

MR. FERLEGER: As to what questions I ask, if you want to object, you can object.

MR. ROTH: I am well aware of the rules of federal court.

I want you to know that I will make the appropriate motion now to terminate this deposition.

MR. FERLEGER: Any motion you wish to (5) make is up to you.

MR. ROTH: Let's proceed. Let's get on to the deposition proper.

THE WITNESS: Mr. Ferleger, what is the proper procedure? If you don't mind, may I ask you a question?

MR. FERLEGER: No, I will be glad to answer any questions you have, if I can.

THE WITNESS: Is it necessary that I have read the memorandum, which I did not see? I have no idea of its contents.

MR. FERLEGER: It is necessary. I was going to try to find out as to whether you were familiar—

THE WITNESS: My capacity is, in addition to being an administrator, as well as a director, a director of a specific specialty service named, "Adolescent Services," at Haverford State Hospital. I am not just one of the hospital's doctors involved in certain cases. Therefore, I must represent my staff.

Secondly, I would like to request that any correspondence or memorandums that were sent to or by Dr. Kremens in regard to this suit, I (6) be allowed to see.

MR. FERLEGER: Certainly. I think the appropriate thing for you to do is to ask your counsel to share with you the legal papers that were filed with the court.

MR. ABRAMSON: I want to mention that at any time if you don't understand or realize what it is we are asking you, or you are not quite clear on it, feel free to ask a question. Don't hesitate because you don't understand what you are being asked. Then again, please do not answer any question until you do understand it.

MR. FERLEGER: In reference to what you just said, doctor, we have asked you to come to this deposition, and what you say here the law requires it be your opinion and your feelings, not the feelings of your staff or Dr. Kremens.

If we had wanted the hospital's position—or personnel—at Haverford State Hospital, we would have asked them to send, under federal rules, a representative of the hospital.

We ask you, Dr. Barbara Armstrong, because you took an oath, to say what your answers are (7) to these questions.

THE WITNESS: That I understand, but there is a condition, in that you ask for, also, at least, a licensed representative presently in the hospital. In that regard, I have to convey information I haven't gathered myself.

Direct Examination

BY MR. FERLEGER:

Q. Can you give us your background, education, and professional experience?

MR. ROTH: If we can dispense with that, or do you plan to attack her credibility as a psychiatrist

or as a licensed psychiatrist who practices at Haverford State Hospital? It would save time.

MR. FERLEGER: She might have more qualifications.

MR. ROTH: Can you indicate the purpose of it?

MR. FERLEGER: Her experience and educational background is certainly relevant in court and—

MR. ROTH: The only way it is relevant (8) is if you are going to attack her credibility as a practicing psychiatrist.

MR. FERLEGER: If I want to qualify her as an expert witness, it is relevant.

MR. ROTH: But the question is whether we can agree she is an expert witness. Do you want her to perform as an expert witness?

MR. FERLEGER: This is discovery.

MR. ROTH: You are fishing.

MR. FERLEGER: I am not fishing.

BY MR. FERLEGER:

Q. (Continued) Where did you go to school?

A. To Temple undergraduate school and Hahnemann Medical College, and the University of Pennsylvania Hospital for Psychiatric Residence, with a specialty in psychiatry.

Q. Did you go from the University of Pennsylvania Hospital to Haverford?

A. No, I was at Devereux for a year, and for three years I was chairman of the Department of Psychiatry for

a U.S. Army hospital in Badcreusnach, Germany, and upon returning to the United States, I took a position at Haverford State, with the purpose of setting up and directing an adolescent service.

(9) Q. Did your work involve adults and adolescents?

A. Child guidance clinic and in an adolescent clinic. So my work did involve both adults and children as chairman of that department.

Q. How long have you been at Haverford?

A. Four years.

Q. How long have you been the Director of Adolescent Services?

A. The entire time.

Q. During these past four years, have you had experience with the court commitments of juveniles, as well as voluntary commitments?

A. Yes, I have.

Q. Have you testified in court hearings?

A. Yes.

Q. For juveniles?

A. Yes.

Q. Have you also been involved in procedures for admission of juveniles, pursuant to application by their parents under the Act?

A. Yes.

Q. Can you tell me, please, what the procedure is at Haverford when parents call up or present themselves or their children at the hospital, saying they want the (10) child to be admitted as a voluntary patient?

A. The hospital has no specific admission policy. It follows the Mental Health and Retardation Act of 1966.

You are familiar with the Act?

Q. I didn't mean the criteria. I am just interested in what happens—

MR. ROTH: I object. I think Dr. Armstrong answered that question. You asked her what procedure occurs at Haverford, and she stated it is in compliance with the Mental Health and Retardation Act.

BY MR. FERLEGER:

Q. The Act says the director makes a finding, but Jack Kremens doesn't do that.

MR. ROTH: I object to this questioning. You asked her what the procedure is and she has informed you.

MR. FERLEGER: Your objection is noted. She can now answer.

MR. ABRAMSON: What we are interested in is not what the Act calls for specifically, but how it is applied at the hospital. In other words, if, for instance, a parent or guardian (11) feels that they would like to have their child, or the person who they are responsible for, enter the hospital, what are your actual mechanics: who do they see; what actually goes on or takes place before the child is or is not admitted, in a very practical sense?

MR. ROTH: I appreciate this elaboration, Mr. Abramson.

We are confining this to 402 and 403 of the Act?

MR. ABRAMSON: Yes.

THE WITNESS: Also, persons 18 years of age and under?

MR. ABRAMSON: Yes.

A. Practically speaking, my understanding of the Mental Health and Retardation Act is such that the director may designate a professional on his staff to make an examination. Subsequently, what happens, this prevents a person, the applicant who is either a parent or guardian, from acting in loco parentis.

The child who is 402, is then brought in for examination. On a 402, it is a prescheduled general admission, therefore, they are examined by one of the members of the Adolescent Services, at which time, a (12) determination is made whether the child needs, in fact, care in the hospital, or what facilities. If it is not indicated, the child is not admitted. If it is indicated, a child is admitted and sent to the appropriate facility. As part of our services, if the child needs the services of the Adolescent Services, then he is admitted to the hospital at large. A social worker, in fact, who is designated as part of the Adolescent Services, then contacts the parent for further personal history or further studies.

Q. Is that initial examination by one of your staff?

A. Generally.

Q. Does that take one day or half a day?

MR. ROTH: I object to that question.

BY MR. FERLEGER:

Q. (Continued) How long?

MR. ROTH: I object to that question.

MR. FERLEGER: She can answer now.

MR. ROTH: I am familiar. I want you to know I don't want you jumping at her.

MR. FERLEGER: I want her to realize that Mr. Roth is objecting for the record as permitted, and you are required to answer.

We don't have a Judge here to rule.

(13) MR. ROTH: But you are permitted to elaborate.

BY MR. FERLEGER:

Q. (Continued) The initial examination after the application—the one you referred to usually by a member of your staff—what is the usual length of time for that examination?

A. We should qualify it and say the examination is by a psychiatrist, not any other discipline, and the length of time is variable. It depends on the individual psychiatrist and whether the child is interviewed alone or with a family member present—anywhere from an hour to three quarters of an hour. On occasion, if it is not done by other staff, it may be the same period of time or shorter.

Q. In a court commitment under Section 406 of the Act, as you probably know, the first part of the procedure involves, usually—the person is not then hospitalized—it involves just lay testimony, is that right, somebody presents a petition?

MR. ROTH: I object to that as being argumentative, and calls for a conclusion of law as to what a 406 commitment is.

(14) BY MR. FERLEGER:

Q. (Continued) I will ask it this way.

When a juvenile is committed under court commitment, you testified that those persons are referred to you, haven't you?

A. Yes, I have.

Q. After you testified—in your experience, very often the court commits the juvenile for a period of 10 days for evaluation and observation; isn't that correct?

A. 10, 30, 60, or an indefinite period.

MR. ROTH: I object to your line of questioning, based on—

BY MR. FERLEGER:

Q. What I mean is this. There have been occasions, haven't there, when the first time you saw a juvenile, the subject of a 406 petition, is when the court committed him to Haverford State Hospital, and directs the hospital to evaluate and observe that person, and after doing this evaluation and observation, you then go back to Harrisburg and report your findings?

A. That happens on occasion, yes.

Q. And that period of time that you have the juvenile for that observation and evaluation is 10 days?

(15) MR. ROTH: Objection to this line of questioning, again, based upon the fact the question is argumentative. Also, by asking that question, you are trying to mislead the witness.

BY MR. FERLEGER:

Q. (Continued) Those occasions when you have gotten the juvenile from the court, when you first see the court—when you get the court papers and records, and are told that this is a court commitment to evaluate and observe—those occasions have happened, haven't they?

A. Yes.

Q. In that case, at some future point, you have gone back to the court and told the court or Master your recommendations and evaluation?

A. Correct.

Q. That takes how long, from the time a person comes in under Section 406 and the time recommendations are made to the—

MR. ROTH: I object to this questioning, again, based upon the fact, number one, the specific question is misleading. The issue is commitment under 402 and 403. Counsel is trying to mislead and draw a parallel between 406 and (16) 402 and 403. Furthermore, if I understand correctly, juveniles 18 and under, 406 applies to everyone.

BY MR. FERLEGER:

Q. (Continued) Answer the question.

A. Your question is: how long does it take? I have to answer you: it takes as long as the court specified. It may be 10. It may be 30. It may take 60. It is specified on the commitment by the court.

MR. ROTH: May I cross-examine at this point, or do I have to wait until the end?

MR. FERLEGER: I think we should wait.

MR. ROTH: Fine.

BY MR. FERLEGER:

Q. Of the juveniles now in your care at Haverford State Hospital, can you tell me how many are committed under Section 402, how many under 403, and how many under 406?

A. You'll have to allow me a moment to count.

Q. Do I have a copy of the document in your hand?

A. You have a copy.

MR. ROTH: That question has already been answered, to which you commented on and we replied to. It is a matter of record. You (17) can find your answer there, too. Furthermore, the current status, as I understand your question—

A. (Continued) I can't answer you currently, as I am answering as advised by your staff, to take the word "currently" to apply to the date we received notification of your deposition.

Q. Whatever you have on your list and what is the date?

MR. ROTH: As long as the date is reflected, and you can answer that approximately.

BY MR. FERLEGER:

Q. (Continued) Do you have a list with you today of the juveniles at Haverford, their ages and commitment sections?

MR. ROTH: Objection. I would appreciate her answering one question at a time.

MR. FERLEGER: I withdraw my previous question.

BY MR. FERLEGER:

Q. (Continued) Do you have a list here today?

A. Yes, I have such a list.

Q. May I have such a copy of it?

A. You may have a copy, but not now, because I don't (18) have one. We have a copy of the data abstracted from all the charts, so to have the information.

MR. FERLEGER: We can save some time if you are agreeable that when I make a copy of this list, that can be adopted as part of her testimony.

MR. ROTH: I would like to see the list. I would like to—am I correct in assuming the people whom you are representing, Mr. Ferleger, have given you their consent to see any records or charts about them; in other words, not only representing them in name, but in substance, and they have given their consent for you to see any information about them?

MR. FERLEGER: Yes. Our complainants have given us authorization, and the hospital to release records to us.

MR. ROTH: As part of the record, if any patient comes against the record to indicate—as you have indicated on record now—that you have full consent of every patient whom you represent?

MR. FERLEGER: That's absolutely correct.

(19) MR. ROTH: Through the patient himself?

MR. FERLEGER: Through the patient.

MR. ROTH: As far as I am concerned, you can make a copy now. I notice that Dr. Armstrong has notes on the back of this. I would appreciate that just the actual typing and not her notes be copied.

MR. FERLEGER: For the record, these are two sheets of paper titled, "Class Action Suit," on which are four columns: Names, Age, Commitment, Assigned.

This will be marked as Exhibit A for identification.

(A document entitled, "Class Action Suit," was marked for identification as Exhibit A.)

BY MR. FERLEGER:

Q. Dr. Armstrong, the named plaintiffs in this case, Kevin Bartley, Steve Gentile, Leslie Levine, Vicki Mathews, and Mark Weand, are you familiar with these people?

A. Yes, I am.

Q. They have been patients at the hospital?

A. Yes.

Q. Have you consulted and read their medical records?

(20) A. Yes, I have.

Q. I would like to ask you a little bit about those people.

Kevin Bartley was committed, wasn't he, on November 30, 1971, by his mother?

A. That's correct.

Q. From your knowledge of him at the time he was committed and the time after that, he would have preferred not to have been in the hospital?

MR. ROTH: Objection.

A. Kevin—

MR. ROTH: Do you want to rephrase your question?

MR. FERLEGER: No.

MR. ROTH: Do you want to repeat it, please? I would like to hear it again.

BY MR. FERLEGER:

Q. At the time he was committed and after that, Kevin would have preferred not to have been at the hospital; isn't that correct?

MR. ROTH: Objection. First, I think I would like to make certain under what section Kevin Bartley came. Has that been established?

MR. FERLEGER: I think it can be (21) established by Exhibit A.

MR. ROTH: You are referring to a specific case. You ought to refer to the commitment procedure utilized.

What commitment procedure?

MR. FERLEGER: That wasn't part of my question. If you want to, you can ask that on cross-examination.

MR. ROTH: You better first get to whether he was committed or admitted.

MR. FERLEGER: That has nothing to do with whether he has objected.

MR. ROTH: You have asked whether he objected to commitment. The question is whether or not he was admitted or committed and the appropriate section.

BY MR. FERLEGER:

Q. (Continued) Do you know under what section Kevin Bartley was admitted or committed?

A. He was committed under Section 403 by his mother.

Q. On November 30, 1971, do you know?

A. That's correct.

Q. Was that against his will or with his will?

A. There is no evidence in the admission note or in
(22) his chart that indicates in writing that he objected.

Q. Dr. Armstrong, we are not confined to the record. I am asking you of your own personal knowledge of him.

MR. ROTH: Objection.

MR. FERLEGER: I haven't finished my question.

MR. ROTH: I know. I am objecting to the line of the question.

Go ahead.

BY MR. FERLEGER:

Q. (Continued) Of your own personal knowledge —first of all, do you know what Kevin looks like?

A. Certainly.

Q. Have you spoken to him?

A. Yes.

Q. Were you a psychiatrist at the hospital?

A. I was the director of the services under which he was under. Dr. Carl Hammer was the individual psychiatrist.

Q. Have you spoken, during the course of his stay, to Dr. Hammer about Mr. Bartley?

A. Certainly.

Q. Of your own knowledge, was Kevin Bartley willing and happy to stay at the hospital?

(23) A. Are you asking if he verbally expressed to me a desire to leave; is that your question? I don't follow your question.

Q. Of your personal knowledge, was Kevin Bartley a willing patient at the hospital?

MR. ROTH: Objection. Willing for what?

MR. FERLEGER: Willing to stay at the hospital.

MR. ROTH: Objection. My objection is based on the point, you can't ask another question unless you withdraw your other question: whether Kevin Bartley, after he was committed, immediately objected to it. She answered he had not, and you asked her whether he was a willing patient. My question is: which question do you want the doctor to answer? I object on the basis that if you are going to ask questions, let her answer them.

MR. FERLEGER: I have been waiting for an answer for a little while.

MR. ROTH: But you have asked two questions.

MR. FERLEGER: I asked more than two.

MR. ROTH: On this particular phase.

(24) BY MR. FERLEGER:

Q. (Continued) On Kevin Bartley, my first question is: was he a willing patient at the hospital? In other words, did he desire of his own volition to remain at Haverford State Hospital to get treated with whatever services your unit provides?

A. Then, I can answer you: yes and no. On occasion, he wished to go home with his mother, who, until approximately a month ago, did not wish him at home,

and on other occasions, he requested to stay. So, both are true: yes and no.

Q. Isn't it true; had it not been for his mother making the application, had it not been the fact that she had initiated the commitment, that he wouldn't have stayed there?

A. No, that's not true. He stayed until it seemed advisable, until he attained sufficient ego control and behavior control. He was given to explosive outbursts.

Q. Did he think he had a problem with his ego control?

A. He thought he had a problem controlling his temper.

Q. He stayed because it was medically advisable?

A. Psychiatric.

(25) Q. He needed to stay at the hospital because of a psychiatric opinion?

A. Well, I would say he did not accept this. We do fulfill the psychiatric needs through the care and facilities of the hospital.

Q. Did he disagree with that psychiatric opinion?

A. On occasions.

Q. Even when he disagreed—

MR. ROTH: Objection. You are harassing the witness.

MR. FERLEGER: I am in the middle of a question.

MR. ROTH: You are harassing the witness. You are going over the same question three times.

MR. FERLEGER: You don't know the end of this question. I am in the middle of it.

BY MR. FERLEGER:

Q. (Continued) Even at the time he objected, he would not have been free to leave the hospital, isn't that true?

A. No, that is untrue. The mechanism is set up for giving notice, providing that the applicant was willing, he would have been signed out against medical (26) advice, even though determined medically and psychiatrically that he remain.

Q. But under those procedures, if the applicant is unwilling, he couldn't have signed out against medical advice?

A. That's true. I qualified my answer by stating when he was ready to leave, he was in fact discharged and not retained for reasons other than psychiatric.

Q. On long-term leave and—

A. Short-term leave. That, I would like to qualify for the record, is for administrative purposes, in order to provide the child the service he needs, namely, transportation from two counties, to Delaware County Intermediate for specified schooling.

Q. Leslie Levine, do you know who she is?

A. Yes, I do.

Q. When and under what section of the Act was she committed?

A. Leslie was admitted on a 403 commitment signed by her mother on 10/11/72.

Q. Where does her mother live?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. (Continued) Where does she live?

(27) A. In suburban Delaware County. I will give you the chart.

Q. Where does her father live?

MR. ROTH: Objection.

A. In Florida.

Q. Are her parents married, separated or divorced?

MR. ROTH: Objection.

A. Divorced.

Q. You read her records, didn't you?

A. Yes.

Q. You read her records and also the other patients' under your care?

A. In compliance with your order, we have prepared summaries specifically for this deposition on all adolescents in the hospital, including the plaintiffs and all others, which includes those not under my care.

Q. May I have them, please?

(Discussion off the record.)

(Copies of patients' summaries were handed to Mr. Ferleger.)

BY MR. FERLEGER:

Q. Dr. Armstrong, I have received from you and your counsel summaries of the commitments of every juvenile now in your unit, or in your unit as of February 15th.

(28) A. In the entire hospital.

Q. Thank you. In the entire hospital at Haverford State Hospital as of the date noted, I suppose, on the summaries; is that correct?

A. No, as of Mr. Abramson's advising us, the date we received your deposition request. What is that, February 23rd?

MR. FERLEGER: I also received dated summaries of the named plaintiffs in this lawsuit.

For the record, for the named plaintiffs, as I said before, I received their consent to seeing their records.

(Discussion off the record.)

MR. FERLEGER: For the record, there are individuals whose brief summaries I have been given from whom we have not received specific consent. These are individuals who are 18 years of age or under, and who have been ordered by the court, members of the class, plaintiffs of this lawsuit.

MR. ROTH: I would just like the record to reflect—and Mr. Ferleger can correct me if I am wrong—that from the statement he has made previously, he has received the consent of (29) all patients to receive and review their medical charts and all material relating thereto.

MR. FERLEGER: I have received consent to look at records of both juveniles and adults at the hospital in two ways. With respect to the named plaintiffs in this case, I received, on individual sheets of paper signed by them, specific consent to see records, and specifying the hospital release those records.

With respect to other persons, including those persons whose summaries will be marked as Exhibit B, I have received consent to see their records by reason of a contract with Haverford State Hospital, approved by Dr. William Beach, a defendant in this case, Deputy Secretary for Mental Health of Pennsylvania, which allows access to all patients' records at the hospital.

MR. ROTH: I would like to make a statement. In addition thereto, I have been informed by—and perhaps misled by—the opposing counsel, that he had received consent from all patients in this case, which included permission to receive and review their records. With regard to viewing these records, and having (30) given these records under the belief and assurances by opposing counsel that he had received the consent of the patients, I hereby charge that unless he has received that consent, that those records are subject to the rules of confidentiality.

MR. FERLEGER: For the record, plaintiffs certainly agree to abide and respect the confidentiality of patients who plaintiffs represent and the plaintiffs in their class in this matter.

The contract with Haverford State Hospital, approved by Dr. William Beach, signed by Dr. Kremens, and approved by Mark Leopold, Assistant Attorney, in Paragraph 11, the hospital agrees to give access to all patients' records and to all areas of the hospital to its professional staff and members. We will abide by the same rules governing hospital personnel having such access.

My questions now are directed to specific summaries of the named plaintiffs from whom we have specific consent, which will be marked as Exhibit C.

(Individual patient summaries were (31) received by Mr. Ferleger from Dr. Armstrong and marked for identification as Exhibit B.)

(Individual patient summaries for named plaintiffs were received by Mr. Ferleger from Dr. Armstrong and marked for identification as Exhibit C.)

BY MR. FERLEGER:

Q. Dr. Armstrong, the statements in all these exhibits are true, aren't they?

A. Yes.

Q. As far as you know?

A. Yes, as far as I know.

Q. You are willing to incorporate them into your testimony?

A. Yes.

Q. With that, we can dispense with reading over every word?

A. Fine.

Q. With reference to Leslie Levine who was at Haverford, do you know where she is now?

MR. ROTH: Objection.

A. No, I don't.

Q. Do you know if she went to Florida to live with her father to complete the school year, as done in the (32) past?

MR. ROTH: Objection. The witness has already answered your question as to where she is since she left the institution.

BY MR. FERLEGER:

Q. Do you know if the patient and her mother agreed to your recommendations to individual therapy while living with her father in Florida?

MR. ROTH: Objection. There has been no foundation laid on this.

MR. FERLEGER: Yes, if this summary of Leslie Levine is true.

MR. ROTH: If you are going to indicate a part of it, indicate the foundation for it.

BY MR. FERLEGER:

Q. (Continued) Have you read the summary?

A. Certainly.

Q. Did you help prepare it?

A. Certainly.

Q. Did you in fact prepare it?

A. No.

Q. With reference to Leslie Levine and with reference to the summary and with reference to what actually happened to her, to your knowledge from medical records, (33) did Leslie and her mother agree to the hospital's recommendation of individual therapy while living with the father in Florida?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. (Continued) Will you answer?

MR. ROTH: No. I want to elaborate.

First, you have just admitted a summary of this person.

Second, you indicated you did not want to go through the summaries with her verbatim, and have already asked Dr. Armstrong if the summaries are true and accurate to the best of her knowledge, and she has answered yes.

Now, you are taking the summaries and admitting or deleting parts of them, and also asking questions about the child's care and treatment subsequent to her release from the institution.

MR. FERLEGER: No, I wasn't. All I asked is if she and her mother agreed to something. I didn't ask if anything happened to her after.

MR. ROTH: Would you like to make a statement of proof?

(34) MR. FERLEGER: No.

MR. ROTH: Then I wish to register a special objection.

BY MR. FERLEGER:

Q. (Continued) Answer the question.

MR. ROTH: Please repeat the question.

BY MR. FERLEGER:

Q. Leslie—do you know her mother's name?

A. Her first name?

MR. ROTH: Objection. It's not relevant.

BY MR. FERLEGER:

Q. Her last name is Levine?

A. Yes.

Q. While Leslie Levine was at that hospital, did Leslie and Mrs. Levine, her mother, wish the patient to live with her father in Florida?

A. Mr. Ferleger, I will answer your question by stating that at the last family conference with Dr. Lustig, who was Leslie's individual and former therapist, they agreed that she would live with her father upon discharge and then they would follow the child on individual therapy. That's the extent of my knowledge.

Q. Why didn't she go home to live with her mother?

A. As the summary indicates, part of Leslie's (35) diagnosis of adolescent adjustment reaction, was extreme

difficulty functioning within her mother's surroundings and with the siblings. It was not psychiatrically wise to repeat that living experience.

Q. And she did better with the father?

A. That's what the history indicates.

Q. With reference to Mark Weand, he was committed under Section 402, June 23, 1972, isn't that true?

A. I have June 24th.

Q. At that time, did he wish to become a patient at Haverford State Hospital, to your knowledge?

A. At the time of his admission he was exhibiting symptoms of being under the influence of unknown drugs—

Q. Can you answer this question, please—

MR. ROTH: Let her answer.

A. He was not able to respond appropriately to any external stimulus.

Q. Your summary doesn't show that he was not able to respond to external stimulus.

A. It says, "Still intoxicated."

Q. It says, "Extremely hostile."

A. I would say being intoxicated.

Q. "Being intoxicated," does that mean you can't respond to any—

(36) A. It does mean any. I would say so.

Q. Subsequently, he was referred to and seen by a psychiatrist?

A. Right.

Q. At the time, did he desire to remain and become a patient at Haverford State Hospital?

A. I can't answer that question. I don't know at that time.

Q. What was the first time you saw him?

A. As indicated in the record, he was placed in a closed unit and was seen by Dr. Harold Rashkis.

Q. What is the first time you saw him?

A. I was answering. When he was transferred to the open unit on 7/12, I then saw the patient.

Q. At that time, did he wish to remain at Haverford State Hospital and remain a patient there?

A. You will have to tell by what indications you wish. He gave no indication, written or oral, to the staff. He indicated—I have the date as approximately two months thereafter—that he wished to leave. At that particular time there was no written or verbal expression made.

Q. At that time later, two months, was he permitted to leave?

(37) A. At that time, for the record, he wrote to the Adolescent staff, not the hospital director, and he was not permitted to leave. It was felt he was not ready to leave, psychiatrically.

Can I add to my answer?

Q. Yes.

A. In addition, it is to be noted that approximately two months thereafter, on September 3rd, the patient was suspected of taking an overdose of drugs.

Q. Dr. Armstrong under some questions I am sure your counsel will ask on cross-examination, and it will save us a lot of time if you try to answer my questions and not anticipate things or add things.

MR. ROTH: I really don't think you can elaborate on a question you ask her.

MR. FERLEGER: Of course not. The fact that he attempted to take an overdose of drugs doesn't

mean anything about the staff not allowing him to leave.

MR. ROTH: Dr. Armstrong, you just answer his questions, no more, no less.

BY MR. FERLEGER:

Q. (Continued) Just in general, in your experience at Haverford State Hospital, there are some children (38) who are happy to be there and happy to get care, and there are some who aren't and don't want to be there?

A. No, I don't think anybody is happy to be in a mental hospital. There are some who are willing to admit that they have problems and who want care, and there are some who aren't willing.

Q. So, there are some who desire to be there and want to get treatment, and some who don't desire to be there and don't want treatment?

A. That's true.

Q. Some of these persons, juveniles, are committed there by courts; isn't that true?

A. True.

Q. Some are either signed in on application of their parents; isn't that right?

A. That's right, true.

Q. There are a number of individuals in your unit who have come in, juveniles, because they want to come in themselves; isn't this true?

A. They are.

MR. ROTH: Objection. I am sorry, counselor. I am not sure I understand the question. If I don't understand, then Dr. Armstrong may not.

(39) BY MR. FERLEGER:

Q. Are there some juveniles who have problems, who appeared stating "I need psychiatric help. I want to be a patient"—who presented themselves, without their parents?

A. Yes.

Q. Are they accepted as patients?

MR. ROTH: Objection. Can you indicate what you mean by "juveniles"?

MR. FERLEGER: For all purposes, when I say "juveniles," I am referring to persons 18 years of age or under.

BY MR. FERLEGER:

Q. (Continued) Are people like that admitted?

A. They can only be admitted under the Mental Health and Retardation Act, which means that they must have someone, either a parent or guardian, and in the absence of either, someone to make a loco parentis application for them to get in.

Q. So, persons 18 years of age or under who wish to be committed and their parents refuse to make application, you don't take them in as patients?

MR. ROTH: Objection. I think the question has already been answered.

(40) BY MR. FERLEGER:

Q. (Continued) You can answer it.

A. There are methods by which we can.

Q. What methods?

A. We would contact the parents and contact the county agency, in this case, the Child Care Agency of Delaware County, and attempt to have guardianship

changed from parent to agency, and have the agency commit the child.

Q. Over the past four years, how many times has that happened?

A. I can't give you a number.

Q. Approximately how many per year?

MR. ROTH: I will register an objection.

A. I am not good at making estimates. It happened not infrequently. I can't give you a number.

Q. In your treatment program of juveniles, do you have a different program for court committed patients, as opposed to patients who are committed under 402, or 403, or is it the same program?

MR. ROTH: Objection. I would like counselor to specify whether people are treated differently, if that's what he is getting at, in terms of psychiatric help; is that your (41) question?

MR. FERLEGER: By treatment, I mean professional psychiatric programs.

MR. ROTH: You are asking about professional—you are asking about whether participation varies according to what section of the law—

MR. FERLEGER: That is a better phrasing.

MR. ROTH: Fine.

A. No. The program is set up to meet the needs of individual children, and the type of commitment has no bearing, except wherein the child—let me see how you should record this. You will need a closed facility for approximately a year or longer for someone who is committed under a murder one charge. Otherwise, for 408 or

406 court commitment: are treated, given ground privileges, and accessability to adolescent closed and open buildings, as their condition indicates.

Q. As their condition indicates, except for extraordinary cases, some criminal charge or court orders, otherwise it makes no difference what section the person is committed under?

MR. ROTH: Objection. You are misleading the witness.

(42) MR. FERLEGER: Why doesn't she tell me?

MR. ROTH: You are just taking her answer and turning it around to mislead her. I object to her answering that at all. You are misleading her completely. She just testified, as I understand it, that it depends on the needs of the person who is admitted—if you heard the beginning.

BY MR. FERLEGER:

Q. Then when you say, "Depending on the needs of a particular patient," then you are—

MR. ROTH: Are you going to specify the specific sections and use that, or I feel I must reject the premise of your question.

MR. FERLEGER: If Dr. Armstrong is mislead, I am sure she will tell you.

THE WITNESS: Okay. I am mislead.

BY MR. FERLEGER:

Q. (Continued) Thank you. Your answer earlier, with reference to—concerning whether the professional treatment program differs upon the court commitment,

what I understood you to say is that except in certain exceptional circumstances— the example you gave us is someone who needs a closed facility because of a (43) murder one charge—except in those exceptional circumstances, the treatment does not vary because of the type of court commitment—voluntary or court commitment?

A. Isn't that what I said?

Q. I am asking you.

A. That's what I said.

Q. Now, in your experience, what relationship have you seen between the progress and outcome of the treatment of juveniles with reference to whether they were committed by court or committed through application of the parents?

A. I can't answer that. The only way I could tell is if we did adequate research.

BY MR. ABRAMSON:

Q. Along that line, but not trying to ask a question that might require extensive research, when you have your meetings with different patients that come under the adolescent unit—

A. Adolescent Service.

Q. —Adolescent Service, do you seem to get the impression from them there may be some antagonism, based on the manner in which they were committed? Should I explain that more?

(44) A. Yes.

Q. In other words, what I am getting at: you meet with juveniles and you see them in your office personally, as I understand it, and you also observe them in the building, and I believe you have also seen all the patients who are currently there as of February 23rd. So, what I am sort of getting at is: do you feel you ever get any feedback

from them with reference to the manner in which they were committed? Do they complain to you or give any specific comments about the commitment procedure? Do they feel any abuse as far as they are personally concerned? Do you get any kind of a feedback from young people?

MR. ROTH: I object to this line of questioning. It is completely irrelevant on the fact there are provisions in the Mental Health Act which qualify why a person is court committed.

I even question whether or not there is any relevancy at all to this line of questioning.

I would request an offer of proof.

BY MR. ABRAMSON:

Q. (Continued) Answer the question.

A. Did I notice as the administrator of the unit, any difference in the attitude of the kids toward their (45) treatment, with reference to the kind of commitment?

Q. No, sort of getting away from the distinction between types of commitment now.

The fact that you are there on a permanent basis, and you have certainly, I believe, a great deal more contact with the patients, especially with the juvenile patients, than we do—

A. I have contact only with juveniles.

Q. —in that sense, I thought you might be able to enlighten us as to any feedback that you have received from juveniles in reference to their commitment, whatever section they were committed under; do you ever have comments from them?

A. Whether they are placed there against their will or with their will?

MR. ROTH: I object. I think Dr. Armstrong has answered that in a general term before, when you said whether people like to stay at the institute or not. I think she adequately answered that. You are giving a general question, yet you want her to answer it specifically.

MR. ABRAMSON: Perhaps I can be more specific.

(46) BY MR. FERLEGER:

Q. Can you answer the question?

A. No, I can't. I don't understand it.

BY MR. ABRAMSON:

Q. Have you ever had one of the juvenile patients make a statement to you concerning the manner in which he was committed?

A. Certainly.

Q. Have these statements from juveniles, minors, concerning the manner in which they were committed, ever reflected any dissatisfaction on their part?

A. Certainly.

Q. Do you feel, professionally speaking, the manner in which they were committed may have had a negative effect on their psychological well-being or mental well-being?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. Can you answer it?

MR. ROTH: The objection is founded upon the basis of the Act itself, where the hospital doesn't admit anybody it feels doesn't need help.

MR. FERLEGER: Dr. Armstrong can still (47) give her personal opinion.

A. The manner in which they are committed hasn't any negative effect on their psychological well-being.

I think the only way I can answer your question is to address myself to the question of someone's being there of their own volition or not being made available of the treatment, and it makes no difference under what manner one is committed, be it loco parentis, or parent, or court. Whatever the circumstance, when someone is unwilling to accept treatment, it is difficult to treat them. The fact they are unwilling is negative psychologically, not the manner.

Q. Thank you. Dr. Armstrong with reference to juveniles who were signed in by their parents at the hospital, do you think you just, professionally, would have a better chance to treat these juveniles if they were committed by the court, as opposed to having been signed in by their parents?

MR. ROTH: Objection.

A. I would have to answer that question the way I answered previously. In my professional opinion, where I am not concerned with the legality, but the treatability of an individual, it matters to those of us as therapists, whether the person presents himself (48) as willing or unwilling. The agency that does the unwilling commitment is not so relevant.

Q. So you don't think it makes such a difference whether the juvenile is committed by his parents, as opposed to having been committed unwillingly by the court?

A. I am sure it makes a difference.

Q. What difference?

A. By the fact that parents—and parents on whom they thrive—have a psychological attachment to their children.

Q. What is the difference—do people have—to children, as opposed to the court, which has no psychological attachment?

I know that is a difficult question.

A. I'm afraid it depends on the individual case.

Q. In cases where you experienced contact, can you tell me what difference it makes to the particular child?

MR. ROTH: Objection. You are going on hypotheticals.

MR. FERLEGER: I am asking on a specific instance.

MR. ROTH: What instance are you referring (49) to?

MR. FERLEGER: In specific, the instance of the children mentioned in Exhibit A.

MR. ROTH: Mark Weand or the entire list?

BY MR. FERLEGER:

Q. (Contniued) Just, if you would, like, outline for us, in your discretion, persons signed in by parents—tell us what difference it made to them in their case or their treatment, whether they were committed by their parents, as opposed to court?

A. The only way I can answer that is to go into each and every individual case. I couldn't generalize. There is no way I can give a generalized statement.

MR. ROTH: I object to the whole line of questioning. What you are doing: you are asking her for

an assumption of how it differs for one who is court committed, how it differs for one voluntarily committed, and how it differs for one who is court committed, and I think the rules speak for themselves, in commitment procedures. She has indicated several times it is impossible to answer that question.

MR. FERLEGER: I am asking for her (50) professional opinion, not an assumption.

BY MR. FERLEGER:

Q. In the Leslie Levine case, that is the case where I understand she didn't get along with her mother and siblings, and her mother is the applicant for her commitment. In that case, would it have made any difference to her or to her treatment if the court had committed her, as opposed to her mother applying for her commitment?

A. I can't answer that. That presupposes knowledge I don't have. In qualifying the admission, it was not because she didn't get along with her parents or her mother, but she can't behave appropriately. Specifically, she chased her mother with a kitchen knife and threatened to kill her.

I can't answer that it matters what agency committed her.

Q. Do you think the hostility that she evidenced toward her mother was increased or decreased by the fact her mother surrendered her to the hospital against her will?

A. My judgment is that it would be increased. Whether that in fact occurred, I can't say.

Q. Wouldn't there be less or an increase in hostility (51) or none at all if an impartial court admitted her?

A. I don't know.

MR. ROTH: Objection. She has answered that question repeatedly now.

BY MR. ABRAMSON:

Q. Dr. Armstrong, I notice on the list of juvenile patients, which was labeled Exhibit A, names of two young people in particular that attracted my attention. I would like to direct questions about them.

One is a young man, Allen Moss, whom I believe is currently still at the hospital.

A. That's correct.

Q. Specifically with reference to Allen, has he indicated to you or any member of your staff any facts with reference to the manner in which he was committed? Perhaps I should add the exhibit also shows he was committed under Section 403 of the Mental Health and Retardation Act. His records would show that he was admitted by his parents; is that correct?

A. That's correct.

Q. Has he indicated to you or members of your staff, any specific comments concerning the manner in which he was admitted?

A. I have not heard of any. Mr. Moss is directly (52) the patient of Dr. Gus Kratsa, K-r-a-t-s-a. Whether at individual therapy he has given some indication, I don't know.

Q. In other words, in the summary, there are no notes making reference to his original admission to the hospital or anything that took place at that time?

A. There are no notes in the summary.

I can add he was transferred from the University of Pennsylvania, and he admitted to being depressed and suicidal.

Q. Doctor, with reference to the third female patient, Deborah Geiger, the exhibit shows her age to be 16, and the type of commitment, under Section 403 of the 1966 Act, and I believe the specific record of her commitment shows she was also committed by her parents.

A. The record so states, Mr. Abramson, however, it also indicates that she wished to be committed, and it was impressed upon her by Dr. Kratsa that under the Mental Health Act, it was necessary that her mother sign her in.

It is a general requirement of the Mental Health Act that we ask the juveniles to sign the 403 paper themselves.

(53) Q. But Allen Moss, how did he come to get to the hospital?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. How did Allen Moss come to be a patient at the hospital?

A. The social worker from the University of Pennsylvania called our in-take social worker and arranged a transfer from the University. He was deemed to be too suicidal to remain in their setting, which is not a psychiatric hospital. He was in their ward.

Q. Then his parents signed him in?

A. Yes.

Q. When did his parents sign him in, as of what date?

A. As of 1/10/73.

Q. When was he transferred physically from the University of Pennsylvania?

A. The same day.

BY MR. ABRAMSON:

Q. So that I can assume then, the specific records that you have, the summary for Deborah Geiger, don't indicate anything with reference to her admission, other (54) than the comments you have already made?

MR. ROTH: Objection. That is misleading, Mr. Abramson. You indicated, "according to specific records of the summary."

MR. ABRAMSON: I am sorry.

BY MR. ABRAMSON:

Q. (Continued) According to the records of the summary you have here before you, doctor, can I assume then, other than the comments you have made, there is nothing else making reference to what took place at that time?

A. No, you can't assume that. The entire chart has additional data. I have extracted some material.

Q. The summary doesn't show additional information concerning her admission?

A. You have a summary before you. I don't see that it has any additional information.

Q. From your knowledge of her specific chart, do you recall any specific information on her chart concerning her admission; from her chart, which is not with us today, do you recall any specific information concerning her admission?

A. That she expressed a desire to Dr. Kratsa to come to the hospital. It's present on her admission, (55) yes.

Q. From your personal knowledge, could you convey any other information concerning her admission, other than what you have already given us?

A. What kind?

Q. Concerning the manner in which she was admitted, her attitude at the time, any facts?

A. She was interviewed in the open unit. Her family was subsequently interviewed, and she requested admission as an alternative to running away. She was considered to be quite upset, despondent, and in need of some treatment, and perhaps the living facilities of the hospital were available and the open unit was offered to her, which she accepted.

Q. Do you recall any information which has come to your attention from a member of your staff concerning the manner in which her parents made her available to your staff at the hospital; in other words, do you have any information concerning how she got to the hospital, other than the fact she came with her parents?

A. Her mother drove her.

BY MR. FERLEGER:

Q. With all the experience you have had with juveniles, would you just tell me—and this is an (56) open-ended question—whether or not you see any reason, or what reasons you do see for juveniles not to be entitled to a 406 court hearing before they can be presented to the hospital against their personal will?

MR. ROTH: Objection.

MR. ABRAMSON: Will you talk to that issue, please?

MR. ROTH: Dr. Armstrong is not qualified to testify on law as you feel it should be.

MR. FERLEGER: I do not wish her to testify on law.

MR. ROTH: You have agreed to her qualifications as an expert witness with regard to her treatment of juveniles specifically, and you have focused on these questions, and in part, you have gone awry.

As far as I am concerned, you are turning this into a fishing expedition. If that is going to continue, I will make the appropriate motion to dispense with the deposition.

BY MR. FERLEGER:

Q. (Continued) Can you answer that question, please?

A. You will need to restate the question.

(57) (The reporter read the last question as follows:

"Q. With all the experience you have had with juveniles, would you just tell me—and this is an open-ended question—whether or not you see any reason, or what reasons you do see for juveniles not to be entitled to a 406 court hearing before they can be presented to the hospital against their personal will?")

A. You are asking for my individual opinion?

Q. Yes, as a human being and psychiatrist.

A. My opinion is only in that area in which I am qualified to speak, and that is quality medical care.

Were the 406 hearing a legal procedure set up to function in a rapid manner, so that the child involved could get adequate care as soon as required, there would be no reason. However, in reality, that does not exist, and I find that insisting upon a court procedure for the admission of an acutely ill child would deprive the child in some instances, in many cases, of rapid institution of adequate psychiatric treatment.

Q. The need for rapid institution and psychiatric treatment could be met, couldn't it, by some emergency procedure, don't you think?

(58) MR. ROTH: Objection.

A. As I understand the present Mental Health and Retardation Act, the emergency procedures under a 405 are extremely difficult to comply with and do not fit all the circumstances in presenting an acutely ill child. Specifically, one must be acutely and observatively homicidal or suicidal and have committed such an act in order to qualify. There are a number of ill children that do not fit that definition.

Q. You said in your answer before, if there was a 406 or other court procedure which would get this effective care quickly for acutely sick children, then, as a professional, that would be satisfactory to you?

A. Are you saying if there was only a court procedure or additional?

Q. If there were two proceedings: one where the child could come in to you and get the care, of his own personal volition, and the other one, where there was a rapid and fair court procedure.

A. I don't think that would, in my own opinion—I think that is too restrictive. I also think there should be a provision for adequately trained medical personnel to effect admission rapidly without requiring a court proceeding.

(59) Q. Would that go to adults as well?

A. I am not qualified to speak for adults.

Q. Are you a psychiatrist?

A. Yes. That's an unfair question, and I am not going to answer that.

Q. You are a psychiatrist?

A. That's correct.

Q. To your knowledge, is there anything different about acute psychiatric problems of adults, which would require that adults also have the procedure you are suggesting, where qualified medical personnel could commit them without a court hearing?

A. I will have to answer your question this way. Yes, I am a psychiatrist, and I have been trained to work with adults first, but I have not practiced adult psychiatry in eight years. There are considerable differences with the acutely ill child, as opposed to acutely ill adult, particularly with reference to the degree of personality growth. Therefore, I can't answer your question.

Q. What are those differences?

MR. ROTH: Objection. This has become a fishing expedition. We are supposed to be focusing on Sections 402 and 403 of the Act. (60) Now you are going off on a tangent about adults and children and are talking in terms of generalities. It is becoming a fishing expedition.

MR. FERLEGER: Mr. Roth, if you will read the complaint, the first cause of action of the complaint alleges violation of equal protection, in terms of the way two classes of juveniles are treated, as well as a difference in the treatment between adults and children.

MR. ROTH: Notwithstanding—

MR. FERLEGER: This is not a fishing expedition to ask questions not only proper on deposition, but even admissible in court.

MR. ROTH: That is questionable, Mr. Ferleger. I appreciate your unrestricted judgment that this is admissible in court.

Secondly, as far as the questions concerning juveniles, along with adults, I believe Dr. Armstrong has already testified, notwithstanding your repeated harassing questions about adults, that she not be asked to testify to the nature of adults treatment or anything of that sort, since she has not been exposed to (61) them for the past eight years, and does treat, specifically, juveniles.

THE WITNESS: We better qualify that. Okay? I will have to change my statement regarding dealing with adults. I certainly deal with adults as far as their being family members, and have, in the past four years, restricted myself to adolescent psychiatry, and no adult patients per se.

MR. FERLEGER: Thank you.

MR. ROTH: Dr. Armstrong does state she was trained first in adult psychiatry. I don't think you would want to impune her qualifications. I am just objecting to your—

MR. FERLEGER: The question I asked her: what are the differences in the acute psychiatric problems of adults versus children—

MR. ROTH: And Dr. Armstrong answered that one of the problems involved is the determination upon permanment development. Now, to go through the whole list of them, I suggest you consult your nearest book on psychiatry and look for yourself, otherwise, it would take forever.

You are talking in generalities. As (62) involved among children, psychiatry is—

BY MR. FERLEGER:

Q. (Continued) Can you tell us any major differences between adult psychiatric difficulties and child psychiatric difficulties?

A. That would, Mr. Ferleger, take the better part of an afternoon. I can't do that. There are multitudinous ego functions that are not developed to the extent that are adults', and to go into each one entirely is too involved.

Q. With reference to those differences in these illnesses between adults and children, those illnesses would make, in your opinion, a sort of different procedure necessary for adults and children?

A. I couldn't say that.

Q. Are there differences between psychiatric problems in children which, in your opinion, would make it essential there be different procedures for bringing them into the hospital?

MR. ROTH: I object to that line of questioning. I think, Mr. Ferleger, or I am—at least I hope I am—well enough aware of the Act to know there are different procedures for adults, as well as procedures for juveniles (63) in the case of their commitments or admissions.

MR. FERLEGER: Mr. Roth, I was not asking for or eliciting your opinions. I am asking for Dr. Armstrong's opinions.

BY MR. FERLEGER:

Q. (Continued) Can you answer that?

A. Tell me the question again.

MR. FERLEGER: Read it back.

(The reporter read the pending question as follows:

"Q. Are there differences between psychiatric problems in children which, in your opinion, would make it essential there be different procedures for bringing them into the hospital?")

A. There are differences between adults' and children's psychiatric problems. We have established that. Whether that, therefore, indicates a different procedure for admission to be followed, I can't answer that.

Q. In your psychiatric opinion—

MR. ROTH: She just indicated she can't answer it.

MR. FERLEGER: Let me try to clarify the question.

(64) BY MR. FERLEGER:

Q. (Continued) Psychiatrically, you can't say then, if I understand you correctly, there are differences which require different procedures; is that a statement of what your feeling is?

A. No.

MR. ROTH: Would you clarify the question, please?

BY MR. FERLEGER:

Q. Would you say what you said then?

MR. ROTH: Say your question.

MR. FERLEGER: My question—there is no need for me to repeat it. This deposition will show what the question is.

She said she can't answer specifically, and I am asking her to state her feelings.

MR. ROTH: She can't answer with a statement. You have asked for her professional and personal opinion.

MR. FERLEGER: Dr. Armstrong was about to say something.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, is your position that you cannot say that there are differences between (65) the mental illness of adults and juveniles, which would require different procedures for admission or commitment to a hospital?

MR. ROTH: Objection. Dr. Armstrong has already answered that question.

A. I didn't say I cannot. What I said was I cannot state, on the basis of the fact there are differences in the kind of problems that children have, as opposed to adults. That in itself, therefore, indicates a difference in admission procedures which should be followed. Certainly the child should be allowed the same facilities as adults. Specifically, children should be allowed to sign themselves into a hospital, assuming they have adequate judgment. This is one of the difficulties in dealing with a child, and what you have to determine upon examination at the time of admission by a qualified psychiatrist. That's one of the major differences, and that's their ability to judge situations adequately.

Insofar as the admission procedure followed, as a conclusion to the assumption and statement, there are differences between mental illness in children and adults, but I can't answer as to the procedure.

Q. In your opinion, do you think the judgment of (66) parents, or guardians, or persons standing in loco parentis is sufficient for proper commitment of children to mental hospitals?

A. I think, under the Mental Health and Retardation Act, at the time the child is examined—

Q. In your opinion, not under the Mental Health Act.

A. I think the answer is yes and no.

Q. Can you explain that?

A. There are some instances where the parents are qualified, the child would not be admitted, which is my answer, under the Mental Health and Retardation Act—the parents would be judged to be qualified. However, on occasions, parents' judgments could be questioned.

Q. Unless the professional person, you included, felt the parents were qualified to make the determination?

A. Certainly. To elucidate, a psychotic parent could not admit a child because he would be judged not to be competent to judge.

BY MR. ABRAMSON:

Q. In your experience at Haverford State Hospital —in your professional experience, can you recall any (67) specific incidents of what you would consider abuses of the admission procedure by parents of young people?

A. I think you are referring to a conversation we had, Mr. Abramson, in checking into the particular cases. The child we were discussing, I believe, was committed under Section 406, so I can't recall that.

Q. You can't recall any case in which a parent has, under Section 402 or 403, for reasons other than the best interests of the child—

MR. ROTH: Objection. I believe Dr. Armstrong has answered the question.

MR. FERLEGER: It was not asked. I believe she has answered that according to the Mental Health Act at the time when persons under 18 are admitted, those doing the application are judged to be competent.

BY MR. FERLEGER:

Q. Once those persons are judged to be competent, then the child is admitted?

A. If the child appears to need admission.

Q. Have you, in your experience, ever come across an incident—I want you to think about this carefully—where parents have used the fact that they were able to petition and could apply under 402 and 403—have (68) used that fact in order to manipulate the child or the Act, contrary to the psychiatric interests of the child?

MR. ROTH: Objection. That question has been asked and answered.

BY MR. FERLEGER:

Q. (Continued) Can you answer that?

MR. ROTH: Furthermore, on the basis of harassing the witness.

A. That is a difficult question to answer. At the same time, I don't know if you are referring to the Exhibit A list.

Q. I am not referring to any exhibit list. I am referring to your past four years at Haverford State Hospital.

A. I don't know. I can't attempt to give you an answer, no. I am sure it occurs.

BY MR. ABRAMSON:

Q. In reference to that statement, do I understand you to say the present admission procedure, as followed by Haverford State Hospital, in accordance with the Mental Health and Retardation Act, allows for such abuses in your opinion?

A. No, it doesn't, because the child is examined on admission, and that has to be based on a qualified (69) psychiatric determination that the admission is necessary psychiatrically.

Q. I think that, Doctor, what I am asking is: does the procedure as followed by Haverford State Hospital, in accordance with the Mental Health and Retardation Act, allow for abuses, not on the part of the hospital or on the part of the admitting physician or whatever, but on the part of the parents? In other words, in their motivation.

MR. ROTH: Objection. The question has been asked and answered.

BY MR. ABRAMSON:

Q. (Continued) I am not asking now for any specific incidents or anything like that. I am asking for your personal opinion as far as the procedure goes, whether it allows for abuses, not on the part of the hospital, but on the part of parents who signed it, to apply as a part of the admission process. They do speak to the admitting physician; they do have the opportunity to convey their thoughts and their opinions about their child or are given some consideration by meeting the physicians. Given those facts, as I understand them, does the doctor feel, personally, that the procedure allows for abuses on the part of parents, again, not on (70) the part of the hospital?

A. I don't think that that's an adequate question, because the child is examined by a qualified psychiatrist, and were the child, regardless of what the parents stated, not in need of hospitalization, the child would not be hospitalized.

BY MR. FERLEGER:

Q. Stopping short of the decision of whether the child is in need of hospitalization, let's assume you have examined the child and you decided, does the procedure, as Mr. Abramson asked you, allow for abuse, even in initiating the application?

MR. ROTH: I object to that question. Dr. Armstrong is a psychiatrist who examines and determines whether or not the patient is a prospective patient, let's put it that way, and is in need of institutional care. What motives are behind the parents' placement of the child into the institution is completely out of the scope and knowledge of Dr. Armstrong. She is not dealing with the parents in admitting the child.

MR. FERLEGER: You heard she does speak to the parents.

(71) MR. ROTH: But you are trying to use that as a weapon in saying the parents are abusing the procedure.

MR. FERLEGER: I am not saying that.

MR. ROTH: That is completely out of the scope of this deposition. Dr. Armstrong can, not only testify as a professional involved, but also in terms of whether or not the prospective complainant needs to be admitted.

BY MR. FERLEGER:

Q. (Continued) We haven't given her a chance to answer that question.

A. I can answer you only insofar as what I said before. The parents' motives are examined. The child also is examined, and if his admission is determined to be necessary, admission takes place.

Q. You have examined parents' motives?

A. I interview parents.

Q. And professionally, you consider their motives and try to make an evaluation of their motives?

MR. ROTH: Objection. Dr. Armstrong discusses the admission with the parents. She does not examine the motives of these parents, and these inuendoes made are incorrect.

(72) BY MR. FERLEGER:

Q. (Continued) Do you examine the motives of the parents? I think you stated you—

MR. ROTH: She does not. If you are going to mislead, I am not going to let her answer.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, do you understand what the word motives means?

A. You can explain it to me.

Q. Do you not examine the motives of the parents who seek admission and commitment of their child?

A. Generally, what I examine is the presenting problem of the child. At the same time, it is not possible to examine motives of the parents at all times.

Q. But sometimes?

A. It depends on an individual case, what the circumstances are involved.

Q. Didn't you state earlier, in answer to my question, that you did examine motives of the parents?

A. No, I interview parents.

Q. In that interview, as I think you answered earlier, you examine the motives of the parents?

MR. ROTH: Objection. She already (73) indicated she does not examine the motives as you have indicated. She indicated that she interviews the parents.

MR. FERLEGER: This record will speak for itself.

A. It's not the admission procedure to examine motives of applicants, but the admission procedure is to examine the needs of the child, based on the psychiatric problems the patient presents.

Q. One of the ways of doing that is by the information gotten from various informants.

MR. ROTH: Objection. It is misleading. You are saying information from sources other than the psychiatrist. From my understanding, it is Dr. Armstrong's testimony that the person is admitted based on the psychiatric evaluation of the child or juvenile in this case, as it is determined whether or not this juvenile needs to be admitted.

BY MR. FERLEGER:

Q. Dr. Armstrong, when parents apply to have their child admitted, the normal procedure is to speak also to the parents; is that so?

A. Yes.

(74) Q. And the parents talk to you?

A. Correct.

Q. Do they tell you things about their child?

A. Certainly.

Q. Those are things you consider in making your professional evaluation?

A. But it is—an attempt is continually made to base any admission or observation on historical data that's presented by the parents. It is not a specific examination of the motives behind the facts.

Q. The parents present you with historical data about the child and you try to evaluate that and find in it, whatever psychiatrically relevant things there are?

A. It is based on continual examination of the child. The data isn't taken at face value.

Q. Have you found a case where some or all of that historical data was incorrect or fallacious?

A. I would say any historical data is subject to the interpretation of the person presenting it.

Q. Have you found a case where the parents, in your opinion, intentionally gave false information about a child they were presenting?

A. I don't know how I would determine that.

(75) Q. Have you ever found that to be true, either later on through other conversations or through social work history records?

A. That's historical data related by parents which is fallacious in part?

Q. Yes.

A. I am sure that occurs. You are asking me for data I can't give you.

Q. In those instances where the information is fallacious or incorrect, the only way you have of checking that is by your asking the patient, or other individuals, or doing your own investigation?

MR. ROTH: Objection. It has already been indicated that when the child becomes a prospective patient at Haverford, that Haverford undergoes its own independent psychiatric examination.

BY MR. FERLEGER:

Q. (Continued) Okay. Can you answer the question?

A. You will have to repeat the question.

(The reporter read the pending question.)

A. Any investigation is made by the available data. The usual admission procedure is that we request any school records, neurological background, examinations, electroencephalograms, medical examinations, (76) preceding psychiatric evaluations, or other ancillary data be presented.

It is not the function of an admitting physician to be a private investigator or check out the total validity of each fact. This is usually when things are correlated with other data that's considered in the total evaluation, but the primary evaluation depends upon the presenting child and symptomatology.

Q. The presented child usually doesn't have a lawyer with him or her?

A. Correct.

Q. Do you interview the parents in or out of the presence of the child?

A. As you are familiar, there are multiple ways of conducting psychiatric examinations. Depending on the individuals background and preference, either the entire family can be interviewed together, the child and parents may be interviewed without other family members, the child may be interviewed individually, and the parents may be interviewed immediately.

Q. Are the parents under oath at that time?

A. No.

Q. Is the child under oath?

A. No.

(77) Q. When you interview the parents privately, is the child informed of the content of those conversations?

A. Certainly.

Q. In what way?

A. If the child is not present, then the usual procedure, at least at Adolescent Services at Haverford, is to ask the child if the child would like to remain present. If the child does not wish to do so, the contents of the interview are explained to the child.

Q. By whom?

A. The examining psychiatrist.

Q. So, in every case then where the parents are interviewed, the child can be present if she wants to, in your Service?

A. That's correct.

(A recess was taken at 12:00 o'clock.)

(The deposition reconvened at 12:10 p.m.)

BY MR. ABRAMSON:

Q. Dr. Armstrong, first I would want to ask you a specific question, in that what I would like to know is: since you have been at Haverford State Hospital, can you recall any incident in which you felt professionally that there was a juvenile at the hospital, for however short a period, who in your opinion, did not require (78) the facilities of the hospital for medical reasons?

A. I can answer that most specifically by stating: in the American Psychiatric Association's diagnostic manual, the diagnostic manual called a diagnosis incorrect as

based on the psychiatric factors found, and that diagnosis was given one child in four years, namely, Cheryl Ann Masagee, M-a-s-a-g-e-e.

However, in reviewing Cheryl's chart, she was placed in a hospital by a civil court commitment on a 406.

Q. With reference to this specific individual, may I ask how long she remained at Haverford State Hospital, not the specific number of days, but do you recall—

A. Approximately three months. To qualify that, it was necessary to: one, change custody of the child for her best interest from her mother who had pressed the court for the 406 commitment, to the child care agency of Delaware County, which needed a court hearing; and secondly, a suitable placement for her, in acting in her best interests, was required. The court proposed to place her in a juvenile detention home, which the Adolescent Service at Haverford State Hospital felt inadvisable, and the child did not wish. Subsequently, a foster home was found by the Legal Aid Vocational (79) Department and was accepted.

Q. Now, specifically with reference to the procedure at Haverford, when a young person at the time of admission is found to be in need of care or treatment under the Act, is it always possible for them to go directly to the juvenile building or Building 9; is it always possible for them to be immediately transferred to Building 9 for care and treatment?

A. The way the Adolescent Service is set up at this particular hospital, namely, Haverford State Hospital, the Adolescent Service operates both a closed service and an open service. The open services mentioned is at Building 9, and admission to the open service is contingent upon the child's ability to maintain adequate social behavior in an open setting.

Where the child is too ill or too impulsive and unable to contain their behavior, it is necessary that they be placed in the closed unit.

Q. In the event that a young person is found to be in a suitable state for the open unit, either at the initial admission procedure or following a period of time in the closed unit, will he immediately be transferred to the open unit, or is that contingent upon there being a vacancy in the open unit?

(80) MR. ROTH: I object to this line of questioning. I mean I don't understand the methodology of the admission and commission procedure attached in this case.

BY MR. FERLEGER:

Q. (Continued) Can I explain it, or is it clear what I am asking?

A. I believe I understand your question. I would like to, before I answer that, state two sentences which are not diverting from your question. The Adolescent Services as set up at Haverford is a service whereby admission to the service must be in accordance with certain criteria, and that includes some degree of order in the intellectual capacity for survival, in the open building. When their condition allows, they are transferred to the open setting.

Two, it is contingent upon the availability of the beds. However, the hospital administration has expanded the capacity for children a hundred percent in the past four or six months, so that in fact the requirement of waiting for a place is usually no more than approximately two to three days.

Q. Have you in your experience been confronted with a situation in which the young person was in the

(81) closed or locked building and it was felt that they were suitable for transfer to the open unit, but yet, this transfer was held up for more than the approximate period of two or three days because of non-availability of space for them?

A. Prior to the availability of the additional half of the building it was true, but again, as the general situation was, it was no more than the maximum of a week.

Q. Thank you. The next question is more of a general nature than a specific nature. Getting back to the admission procedure, when a patient comes in with their parent to the hospital, and at some point it becomes clear to the child he is being brought to the hospital to be evaluated, with the possibility they may be admitted to the hospital, do you feel professionally that the knowledge of their impending commitment or admission to the hospital may have an effect on the image, what they present to the admitting physician, or perhaps, on their mental state at the time of the admission procedure?

MR. ROTH: I object on the basis that this question has been asked before and answered before.

(82) A. It may. It would depend, as I answered before, on the degree of volition with which the child presents itself. If the child is willing to come, it's a positive effect. If the child is negative regarding admission, the knowledge may have an effect and it may not. There is no general situation that may be given.

Q. You mentioned there was a practice at Haverford State Hospital, I believe, where if the child was favorable to admission, that you often allow them to sign the formal papers, as well as their parents?

A. This is the practice of the Adolescent Service itself, and the child is requested to sign in all instances; and in my personal dealings, the child has so done.

Q. In all instances, as I understand you to say, this is where the child was favorable to admission?

A. Right.

Q. This question may seem rather basic, but do you feel that allowing them to sign themselves in is beneficial to—

A. It allows them to have responsibility over their subsequent fate. So, it is rather obvious—

Q. Responsibility over their subsequent fate?

A. In their admission.

(83) Q. In other words, so that they are on record as favoring it? Is that what you mean? Because I understand it wouldn't affect their release. The fact they signed initially would not require that they signed to be released?

A. If I can amplify the procedure of the Adolescent Service again: wherein a 403 voluntarily committed child, 18 or under, wishes to be released, they are so advised by our staff to write to the hospital director of their desire to leave, and within the 10 days subsequent, their parents are notified, either by the child, which is requested, or by the staff—and in all cases, by the staff—and a conference is held, and either the commitment is then recommended to be changed to a 406 or the child may be released. This is amplified in the present Mental Health and Retardation Act. Because, under the Act, it states that the applicant or someone acting on the applicant's behalf, must write to the hospital director—in this case, the child—and this gives them their constitutional right guaranteed them by law.

Q. If the applicant does not wish to consent in writing, solely by this fact, the child would not gain the release?

(84) A. Yes, it does not affect their release. It does in the Adolescent Service, however, in all instances that I can currently remember. There may be exceptions that have caused the social service to reflect their views, to change the commitment to a civil court commitment.

Q. But you don't know whether this procedure or other ones is followed in other facilities across the state?

A. I have no knowledge.

BY MR. ABRAMSON:

Q. With reference again to the admission procedure, in the event an admitting physician does not feel that the juvenile brought in by the parents is in need of care and treatment at the facility, is there anything, to your knowledge, to prevent the parents from then attempting to admit the child to another facility within the state?

A. No. To my knowledge, there is no legal machinery that protects the child. There is no central clearing agency that has all daily admissions and evaluations in a memory bank, so to speak.

(Discussion off the record.)

BY MR. FERLEGER:

Q. Do you have, Dr. Armstrong, all correspondence, books, records, and documents relating to placement (85) criteria of the Department of Public Welfare for admission or commitment of juveniles, as you were requested to bring?

A. I consulted with the hospital director regarding your request. Haverford State Hospital has no additional

records, documents, books, or correspondence relating to admission, other than the Mental Health Act itself.

Q. The Department of Public Welfare, do they have any other such records or documents?

MR. ROTH: I object to that. I don't think Dr. Armstrong can answer as to what they have. She can only answer for the institution she is employed by.

MR. FERLEGER: If she can't answer, she can tell us.

A. I don't know.

Q. Have you seen, Dr. Armstrong, the answers to the first set of interrogatories that were signed by Mr. Roth?

A. Yes, I have.

Q. Do you have them here?

A. Yes.

(The witness handed a document to Mr. Ferleger.)

(86) BY MR. FERLEGER:

Q. Now, in your experience at Havorford State Hospital, is it correct that the standards used for admission or commitment of juveniles and those standards used for adults are the same, namely, that they're based upon the Mental Health Act standards for the mentally disabled and in need of care and treatment?

A. I don't understand your question.

Q. I will rephrase it. What are the criteria for admission or commitment of juveniles to Haverford?

MR. ROTH: Objection. I am not certain I understand the question. Are you talking about a professional opinion, whether or not the child is in need of institutionalization, or the law itself?

MR. FERLEGER: I am asking what the criteria are.

MR. ROTH: With regard to what?

MR. FERLEGER: Admission or commitment of juveniles. You seem to—

MR. ROTH: I don't understand your question.

MR. FERLEGER: You seemed to understand it well enough in the interrogatories. I am (87) asking the same question you answered and gave your name to.

MR. ROTH: I would like the question clarified for the witness.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, what are the standards or criteria you used in an attempt of admitting—

MR. ROTH: Objection.

A. I would say—

MR. ROTH: I can object on behalf—

MR. FERLEGER: You can permit her to answer.

MR. ROTH: I am merely objecting on the basis of what I understand is the Mental Health and—

MR. FERLEGER: You are answering for her, and your objection is fine, but do not answer for her.

MR. ROTH: I am not answering for her.

A. The criteria are the same criteria as in the Mental Health and Retardation Act itself.

Q. Which are what?

A. I don't have to read the entire thing?

(88) Q. The criteria you used from the Mental Health and Retardation Act for admission or commitment of juveniles to a facility?

MR. ROTH: At this time, would you like to stipulate as to what section, 402 or Section 403 say, or would you have Dr. Armstrong read it into the record?

BY MR. FERLEGER:

Q. (Continued) Read into the record that portion which gives the standards and criteria, if they are used, for juveniles.

A. The entire listing of things which are under the mental disability statement, which are under Article 1.

Q. What section of that; what section of the Act?

MR. ROTH: I object first, on the basis I don't know where you are going with this line of questioning. I would like an offer of proof before we get into the Mental Health and Retardation Act of 1966.

BY MR. FERLEGER:

Q. (Continued) You are referring to Section 102, to the definition of mental disability; is that correct?

A. That's what I am referring to.

(89) Q. And if I understand you correctly, this gives the definition of who suffers from mental disability, as defined there, who would be eligible for commitment?

A. Correct.

Q. To your knowledge, that definition of mental disability is also used for admission or commitment of adults as well?

A. To my knowledge.

MR. FERLEGER: Dr. Armstrong and Mr. Roth, I think we have agreed previously that in order to dispense with the necessity of Dr. Armstrong having here all the medical charts of all juveniles who are presently patients at Haverford State Hospital and named plaintiffs, that plaintiffs' counsel will be permitted to examine the correspondence, book records, and documents at Haverford State Hospital. Do we agree, or do you want to add something?

MR. ROTH: My understanding is Mr. Ferleger has an agreement with Haverford State Hospital which grants him access to all the information that he has addressed himself to, and my direction would be that he would be allowed to review those records, and also, it (90) would be my understanding, as I hoped it was Mr. Ferleger's, that he would use those to the best interests of these patients.

MR. FERLEGER: No doubt about it. Just to clarify things, on Exhibit A, there are three individuals there whose names there are lines through.

THE WITNESS: They are for a 408 criminal court commitment, and in our desire to supply you with all necessary data, we overextended available information.

MR. FERLEGER: Our request did pertain to all juveniles.

THE WITNESS: Then you do want them.

MR. ROTH: Your request directs itself to voluntary admissions. Are you referring to No. 9 of interrogatories?

MR. FERLEGER: No. Our notice of deposition refers to all juveniles who are presently patients.

David Rhinehart, age 16; Elizabeth Schriber, age 14; and Stephen Willett, age 16.

MR. ROTH: As far as I am concerned, since you have access to the records and we have (91) addressed ourselves to that, you are permitted to review them according to those juveniles presently in the facility.

MR. FERLEGER: Your turn.

MR. ABRAMSON: May I ask one question?

BY MR. ABRAMSON:

Q. I wanted to ask: if a juvenile is a patient at the hospital under either Section 402 or 403, and a parent comes to the hospital and would like to withdraw the child from the hospital, and the hospital has no objection, does the hospital concern itself with the future disposition of the child?

A. Yes. That's a useful question, I think. The hospital and the psychiatric staff, the psychologist, the social service nurse, and the lab services are, as part of their agreement to offer services in the examination, care, and treatment of the child, are required to recommend outpatient treatment if there is indeed a recommendation.

In Haverford State Hospital's instance, the outpatient clinic has been discontinued, and therefore, outpatient care is referred to four base service units in Delaware County. In other instances, if private therapy can be arranged, that is recommended, in (92) addition to the Department of Family Therapy at Haverford State Hos-

pital. Haverford State Hospital has an agreement with those patients involved in family therapy to continue three months of outpatient treatment.

In all instances, if further treatment is recommended, specific recommendations are given to both the child and the parents. Where an additional agency is involved, such as the probation department, the probation officer is consulted prior to the child leaving, and reasonably, at least regarding the child's needs and the hospital's recommendations, requirements are set up. All liaison with any social agency is attempted to be implemented for the child's care, and are worked with and met with prior to discharge so that the child's care does not stop when the child is discharged.

BY MR. FERLEGER:

Q. If the parents want the child out—if he has given notice to withdraw the application and you feel the child needs inpatient care, then, as I understand your testimony today, there are two things that can happen to him: either the child would be permitted to sign against medical advice, or, in your judgment, might have to have some child care or other (93) agency press for court commitment?

A. That's correct.

Q. Of the people listed in Exhibit A, can you tell me if you know which persons are there as a result of your having to do—to ask for a court commitment when the parents wanted the child out?

A. When the parent wanted the child out?

Q. That's correct. Are there any people there?

A. There are none.

Q. So that doesn't happen very often, I guess?

A. I am sorry. There is a correction. Your question was—can you tell me your question again?

Q. Are there people listed on Exhibit A, with reference to whom the parents have asked the application be withdrawn, with reference to whom you have had to ask or have an agency ask the court for a 406 commitment?

MR. ROTH: Objection.

A. Never mind. You are focusing on whether the application is withdrawn?

Q. Yes.

A. You are asking me if there are any patients whom we have had to request the commitment be changed? You do understand the parents have a right to disagree with our request, and a child, where this occurred—(94) and the resolution of the case—Mary Lou Gallagher—against medical advice, because the parents refused to institute a 406.

Q. Could you institute a 406?

A. There is no way in which, at any time, the hospital can act in loco parentis with the parents' disagreement.

Q. Then what I stated before is incorrect; if the parents disagree with you, your only alternative is to have a child sign out against medical advice?

A. That's correct.

Q. The reason is, even though you personally administer psychiatric care, you are not in a position to apply to the court?

A. That's correct.

BY MR. ABRAMSON:

Q. Doctor, is it also true with reference to recommendations you indicated are often made following dis-

charge of a patient, when you make certain recommendations to parents for continued care or whatever you mentioned previously, again, the hospital has no machinery in which to expel the complaints?

A. No. However, it should be noted, our major emphasis is dealing with the child, and with the (95) exception of a very small percentage, the children themselves, once they are worked with, are advised of their need for treatment and they are given the available base service unit address, phone number, et cetera, so they themselves may seek out their treatment, regardless of their parents' desires.

Q. But if a patient, a juvenile, changes his or her mind, you don't have authority to expel him or her?

A. No. The probation office does. We do not.

MR. FERLEGER: If the child happens to be under probation.

No more questions.

Your turn.

Cross-Examination

BY MR. ROTH:

Q. Dr. Armstrong, let's take a hypothetical situation and follow it through. If a parent wishes to admit a child to your institution under Section 402 or Section 403 of the Mental Health and Retardation Act, what is the first procedure which you utilize?

MR. FERLEGER: Objection. We went through this before, and you objected.

MR. ROTH: That is not true.

(96) BY MR. ROTH:

Q. (Continued) What is the procedure you utilize?

A. The parent is referred to a designated social worker of the Adolescent Service, and what is stated as an in-take interview is arranged with the parents, is one instance. On other occasions and more frequently, the entire family is given an appointment and a joint interview with a psychiatrist and social worker is held to determine whether or not the child requires admission and care.

Q. From what you have indicated in your examination by Mr. Ferleger and Mr. Abramson, it appears that if a child is admitted, or applied for admission other than by his parents, then you make a psychiatric examination. Do you, at that time, determine, based upon your examination, whether the best interests of this child are going to be served by institutionalization?

A. (No response)

Q. In other words, do you determine that the child needs institutionalization, based on an independent psychiatric examination?

A. Certainly.

Q. Now, if this child does not need institutionalization, do you still institutionalize him?

(97) A. No.

Q. If the parents, for any motive other than the best interests of the child, try to petition for his admission into the institution, do you, nonetheless, still conduct an independent psychiatric examination to determine whether or not this child needs institutionalization?

A. Yes.

MR. FERLEGER: Do I understand you to be inquiring into the motives—whether Dr. Armstrong

inquires into the motives or reasons of the parents' interests in committing the child?

MR. ROTH: According to the rules of the court, I am completely within the realm of the examination placed upon the witness before.

MR. FERLEGER: I have to ask you to clarify the question in order to determine whether or not an objection is necessary.

Do I understand you to be asking Dr. Armstrong if she inquired into the motives of the parents, and as a result of that, if the motives are improper, she determines not to institutionalize the child?

(98) MR. ROTH: I will repeat my question for you, if you will listen carefully.

BY MR. ROTH:

Q. (Continued) Notwithstanding the parents' reasons for appliance for admission for their child, does the institution conduct an independent examination in order to determine if a child is in need of institution care?

A. Certainly. In all instances, I would say an examination of the child is made.

Q. Let's say the child is admitted to the institution. After the child is admitted to the institution, and without getting into what kind of care or treatment is provided by your institution, in the event that the child is deemed to be sufficiently capable, in accordance with whatever medical or professional terms you used, what do you do? Do you recommend to the parents, his release? What procedures do you utilize then?

A. Repeat that.

Q. For example, after somebody has been admitted, and because of your care and treatment, is now sufficiently capable to return to society and eventually, to the family home, what do you do at that time?

A. We recommend to the child that his discharge be (99) effected, and we notify the parents of the same.

Q. Usually, when you do that, do the parents comply with you?

A. Yes, usually.

Q. In the event that the parent wishes to release his child from your institution, can you, at that time, indicate to the parent whether or not it is in the best interests of the child for him or her to be released?

A. Yes.

Q. Do you have instances where the child can be released, notwithstanding, medically, that it would not be in the best interests of the child to be released?

A. Certainly.

Q. If a child who is in the institution, objects to being institutionalized, do you follow that objection up at all with talking with anyone about it?

A. Certainly. The child is, as previously stated, advised by the entire staff to write a letter to the hospital director, Dr. Jack B. Kremens, and state that he wishes to leave the hospital. At such time, he is informed that he must inform his parents, and the staff also does. The staff, if the child is in need of further hospitalization, recommends the child's commitment, in 10 days as specified by law, be changed (100) to a civil court commitment, a 406. If the parents comply, this is done. If a parent does not, then the child is discharged.

Q. The summaries which you prepared today, on who were admitted, to wit, Exhibit B, were they—I believe—were the contents supplied in terms of requests,

on those summaries, which you discussed with opposing counsel?

A. Yes, they were, on an unofficial basis. Mr. Abramson has functioned as an unofficial advisor from Mr. Ferleger's staff for the Adolescent Service, and specifically, the Service's social worker, who made this form up for purposes of this deposition, and checked with Mr. Abramson as to its relevancy and completeness.

Q. Dr. Armstrong, questions have been asked of you with regard to examination, its length of time, under 406, as well as under 402 and 403. Is it your professional opinion that notwithstanding the procedures under which an applicant or court committed person comes into your institution, a substantial examination is carried out in order to determine whether or not this juvenile in this case needs institutionalizing?

A. Yes. I would add to my previous testimony, that (101) in this hospital's administrative procedure, there is an initial examination made by the psychiatrist, and is so designated as an admission note on the hospital record. Subsequently, for all adolescents on the Adolescent Service at Haverford State Hospital, there are routine studies done, such as an electroencephalogram, a neurological examination, a medical examination, and a complete battery of psychological tests and school evaluation, as well as a psychiatric evaluation. When all their data has been compiled, an entire staff conference is held, which is called a new case conference, at which point the complete case is re-examined and it is decided whether or not the child needs hospitalization, and at that same time, as well, an adequate treatment course is planned.

Q. Are periodic reports made and revealed to the patient and the parents for the basis of his continued need to be institutionalized?

MR. FERLEGER: I object. That is true of every hospital. That is standard and a required psychiatric practice that I don't think any institution in the State of Pennsylvania would say it doesn't follow. I would be horrified, and so would the doctor, if they (102) didn't continually work with the child and tell the patient what was happening.

BY MR. ROTH:

Q. (Continued) Would you answer the question, please?

A. Insofar as notifying the patient and his parents, or the applicant if it is not the parents, of the patient's status, the social worker is designated every 30 days to notify all admissions, regardless of types, of their status.

The parent or parents, or guardian, are met with, generally, weekly in some cases, to discuss the case. There is some social work counseling done in family therapy, and there are administrative parents conferences, the minimum of which are held once a month.

Additionally, as far as the patients' status and progress is concerned, in the Adolescent Service, there is a detailed progress report compiled by the Department of Research and Planning, in conjunction with Dr. Aaron Smith, wherein the patient's status is noted daily.

Q. Dr. Armstrong, you can correct me if I am wrong: one of the questions about the distinction between adult and juvenile was your admission procedure. Was your (103) answer that children by and large are unable to exercise judgment in determining whether or not they need care?

A. I would have to answer that question the same as I previously answered: yes and no. Some children are

able to exercise adequate judgment, depending on the nature and severity of their psychiatric condition, and their reasons thereof. To others, they are incapable. Their judgment is rendered non-functional by the basis of severe psychiatric problems.

Q. Dr. Armstrong, would it be your professional opinion that it is because the child, in particular, juveniles who are unemancipated—by that I mean living with their parents—could best be observed by their parents who can indicate to you that the child does need additional treatment or treatment per se?

MR. FERLEGER: Objection. Not only does Dr. Armstrong not know the legal definition of unemancipated, but your definition: someone living with his parents, is incorrect under the law of Pennsylvania. Under the law of Pennsylvania, a child can be living at home and still be emancipated.

Dr. Armstrong may know, because I wrote a letter, a legal opinion letter, with reference (104) to Trevor Haviland at the hospital, whether the child is emancipated and whether their family knows what this means legally.

I think that makes that question improbable.

BY MR. ROTH:

Q. (Continued) Let me rephrase the question.

In an environment where you have parents and a child living together, would you feel it is appropriate because of the relationship, because of the continual interaction among those people, for the parents to be best apprised in order to indicate to you or the institution that their child be in need of institutionalization?

A. I would have to answer that question as I did previously: yes and no. It would depend on the degree of stability and absence of mental disability, and the degree of maturity of the parents, the relationship of the child and the parents, and again, multitudinous other facts. In some cases, they would be the best observers, where the interaction is positive, and where the interaction is negative, they would not be.

Q. If parents would attempt to admit their child and your institution felt the admission was (105) inappropriate, your institution would not admit the child; is that correct?

A. That's correct.

Q. By and large, Dr. Armstrong, are most of the juveniles admitted or committed to your institution done so voluntarily by the child?

A. That requires the same estimate that Mr. Ferleger asked previously. Some are and some are not. To give you a figure, if you wish, I could count them from this list.

Q. Fine. Again, I am directing this question to the admission from the very outset, and not to subsequent development.

A. If the child requested admission; is that right?

Q. I am asking whether the child objected to his being admitted.

MR. FERLEGER: Go over each name and say—

MR. ROTH: No, I object to that.

BY MR. ROTH:

Q. (Continued) You do it on the whole basis. Say how many for and how many against.

(Discussion off the record.)

A. I think I need to qualify it. Do you mean (106) objected as far as I know at the time of admission, or objected at any time?

Q. Admission. I am also confining this to 402 and 403 commitments.

A. All right. Then those that did not object at all—

Q. Just strictly from admission.

A. Which must exclude six of the children on this list who are severely mentally retarded and cannot be considered competent—there are nine.

MR. FERLEGER: Who did not or did?

THE WITNESS: Who did not object—of 403?

MR. FERLEGER: And 402 is?

THE WITNESS: Okay. That is—

BY MR. ROTH:

Q. How many objected?

MR. FERLEGER: I think it is clear that if nine did not object, the rest objected, except for the retarded.

THE WITNESS: No, because in addition, some are severely psychotic and objection has no reference.

BY MR. ROTH:

Q. (Continued) If I understand, you are indicating (107) nine did not object, and that six were severely retarded, and some of the remainder are not able to exercise judgment in order to object and not object?

A. That's correct.

Q. And you indicated, such as Steve Gentile; is that correct?

A. For example, yes.

Q. Let me ask you this. As far as the named individuals in this particular lawsuit, could you tell me if they are currently in the institution?

MR. ABRAMSON: She has to answer your other question for us.

A. Just a moment. First of all, I am going to correct the first number. Speaking of those admissions, there are 16 that did not object at the time of admission. There are eight that objected, and the remainder are not competent, are severely retarded or psychotic, and cannot make an adequate judgment.

Q. Now, of those who objected at admission, what, if you will, deference did you give to their objection? How do you cope with an objection?

A. Well, it depends on individual instances again. If they are under a 406 or 408 as three were—

Q. So, three of the six who objected were under 408 (108) or 406?

A. That's correct.

Q. Court commitment? Some of the remainder of the remaining—

(Discussion off the record.)

BY MR. ROTH:

Q. (Continued) For clarification of the record, what you have indicated is 16 did not object, eight objected, and of the eight who objected, three came under the court committed procedure, with regard to Section 408 or Section 406; is that correct?

A. That's correct.

Q. Some of the remainder of those who objected were under 402 or 403, and there would be five?

A. Correct.

Q. Could you tell us what deference you gave to objections of those committed under 402 or 403?

A. They were advised to write to the hospital director of their desire to leave. We thoroughly researched their charts. It must be noted that on my list, only one of Mr. Ferleger's plaintiffs remains. However, of this list, none so instituted the writing of a letter to the hospital director, so there was no formal action taken by them, even though they had been (109) advised of the proper action to institute their discharge.

Q. Of those five, Dr. Armstrong, who objected, did you also notify their parents that they were objecting?

A. No, we did not. In this same procedure, if they would have written to the hospital director, the parents would be told at the weekly parent conference. They were not notified by a specific phone call. Had they initiated the writing of a letter to the hospital director—

Q. But the parents subsequently were notified?

A. Correct.

Q. Of the named plaintiffs in this case, how many remain in Haverford State Hospital?

A. None remain, however, Kevin Bartley is continued on short-term leave, as previously explained, for administrative purposes only. This allows him to procure transportation from both Delaware County and Chester County to attend Delaware County's intermediate special adolescent school.

Q. Do you know—

MR. FERLEGER: Is Kevin Bartley the only person on any sort of leave, and are the other people discharged?

(110) THE WITNESS: They are.

BY MR. ROTH:

Q. (Continued) According to your personal knowledge, do you know when those children objected, who are being represented by opposing counsel, whether opposing counsel proceeded to process any writs of habeas corpus to have these people released?

MR. FERLEGER: Objection. That doesn't have any relevance to either this proceeding or the court.

A. To my knowledge, they were filed.

Q. Dr. Armstrong, I just want to emphasize again: does your institution hospitalize anyone who does not require hospitalization?

MR. FERLEGER: Objection. That is repetitious of two of your questions and five of mine.

A. I cannot answer for anyone, Mr. Roth, as I previously stated. By experience at this institution as director of the Adolescent Service and my experience, of which 99 percent is with juveniles, I may say, on rare occasions I will do a professional colleague a favor and do his duty, which may require my admitting an adult. Very rarely under those circumstances do I (111) encounter an adult admitting their requiring admission.

Q. I gather from what you said, if your institution feels that a child no longer is in need of institutionalization, that you effect the proper procedure in order to have that child discharged or released; is that correct?

A. That's correct.

(Discussion off the record.)

BY MR. ROTH:

Q. Dr. Armstrong, in your professional opinion, do you feel that anyone, be it juvenile or adult—and this is

general—could best be evaluated by a psychiatrist, as your institution has, and by that procedure implemented, to determine whether or not that person needs institutionalization?

MR. FERLEGER: Objection. What do you mean by "best"?

BY MR. ROTH:

Q. (Continued) Could be evaluated by your institution in order to determine whether or not this person needs institutionalization?

A. Could you repeat that?

MR. FERLEGER: Objection. I think you are misleading the witness.

(112) BY MR. ROTH:

Q. In other words, what I am asking you is if any persons had wanted to be admitted to your institution—and I believe we are all well enough aware that we are now going into the realm of medical, professional, psychiatry evaluation—would it be your opinion that your institution could do this and does it?

MR. FERLEGER: Objection. The law is quite clear. Despite the requirements of the institution, a person cannot be committed solely on sight recommendations of any number of doctors. So, the fact that Dr. Armstrong thinks that—

MR. ROTH: I am merely asking her in her professional opinion.

MR. FERLEGER: Whether Dr. Armstrong feels that a doctor should have authority to evaluate and sign people into hospitals, in reference to adults in this state, it is quite clear that doctors do not have that authority.

BY MR. ROTH:

Q. (Continued) Can you answer that question without referring to any legal procedures, which Mr. Ferleger has led you to believe are incorrect?

MR. FERLEGER: I mean you are trying to (113) limit her answer.

BY MR. ROTH:

Q. (Continued) Can you answer my question, please?

A. Can you repeat the question again?

Q. From what I see, your institution, notwithstanding the voluntary admission, can make an independent determination to preclude admitting some patients?

A. That's correct.

Q. By the same token, can your institution make an independent determination to ascertain whether a person needs institutional care?

A. The institution does so by examination. The psychiatrist can, as I understand the present law, recommend hospitalization. They cannot institute it.

Q. Fine. But your institution can preclude the admission of someone under 402 or 403 if it feels that person does not need to be institutionalized?

A. That's correct.

Redirect Examination

BY MR. FERLEGER:

Q. What are the names of the persons in Exhibit A who objected to hospitalization? You referred to the number originally as eight in response to Mr. Roth.

(114) A. I want to make it clear that you are asking me for my professional opinion, which is based on memory, and it may well be that you will not find evidence of this in any record. However, in your questioning, you did not confine yourself to written facts, so I am giving my opinion.

One is Kevin Bartley; two is John Cross; three is Michael King; four is Ben Mosco; five is Thomas Hockenberry—we are including No. 405?

Q. Yes.

A. Graber, James.

And we are including 408; right?

Q. Yes.

A. Elizabeth Schriber.

Q. How about Rhinehart?

A. He preferred to come rather than go to jail.

Richard Burns; Anita Jenkins; Stephen Willett.

MR. ROTH: That's all?

THE WITNESS: That's the best I can do.

BY MR. FERLEGER:

Q. By my count, the number of names you have is 10 who objected.

A. You may be right.

Q. Of the remaining people, how many of them objected (115) to being hospitalized during the time of their hospitalization at any time during the time of their hospitalization?

A. We are using the definition of objected, as I have heard them object?

Q. Or you know from your associates that he objected or gave written notice?

A. None have given written notice.

Q. Of these other people.

A. None on the entire list.

Q. And how about in any way to staff members?

A. I have to add, insofar as my knowledge, it's incomplete.

What are you going to do about competent and incompetent people?

Q. If they have objected, then say so. Then say objected, but incompetent people. If they are incompetent, why don't you say—

A. I will run down the entire list.

Q. Except for the ten people you just mentioned.

A. Timothy Baer, objected, not competent.

MR. ROTH: You also included Timothy Baer as one of the 10, didn't you?

THE WITNESS: No, Bartley.

(116) A. (Continued) Mary Lou Gallagher.

Q. What about Suzanne Garrelli?

A. She came voluntarily.

Mary Lou Gallagher objected and signed out against medical advice, which I previously stated.

Stephen Gentile, not competent.

Pollock, Michael, objected and obtained his own court hearing. He is under 406.

Do you want the resolution of that?

Q. No.

A. Okay. David Rhinehart objected.

Michael Vantine objected.

David Parmet is not competent.

William Cutilli is not competent.

Thomas Taylor objects.

Peggy Ann Saunders is retarded, minimally competent, no objection.

Walter Lucas is not competent.

MR. ROTH: Had Walter Lucas objected?

THE WITNESS: Not to my knowledge. They are part of the Adolescent Service.

BY MR. FERLEGER:

Q. The others what?

A. In this list are even a number of children who (117) were not accepted into the Adolescent Service by virtue of either being too severely brain damaged or too retarded to participate in the program.

Q. Doctor, with reference to being accepted into your program or not being part of your program—

A. By virtue of present retardation, they are considered not competent.

Q. Which are they?

A. Walter Lucas.

Q. Point No. 2, you stated that the social worker, every 30 days, gives notice to the juveniles that are there under 402 or 403 commitment. In what way do they give that notice?

A. They verbally inform both the child and the parents. Either the parents are notified by telephone or informed by the weekly conferences.

Q. Is the fact that this information has been given to parents noted on the medical charts?

A. No, it is part of the routine procedure. However, in checking with the social service department, since the papers of a 403 are to be resigned every 30 days, the resigning itself is sufficient notification and, therefore, no notation is made.

Q. What is the notification of parents?

(118) A. That the child is notified verbally.

Q. Dr. Armstrong, two or three months ago, David Purcell of your staff kindly invited me to come to one of your staff meetings, and at that meeting, certain procedures happened, and I would like to describe it for you and ask you whether that procedure of your staff is typical. This follows with reference to what Mr. Roth asked you about.

A patient had given a letter to the staff, expressing his desire and intention, if permitted, to leave. This matter was brought before the staff members as an assembled staff of psychiatric aides, doctors, and there was a discussion by the staff of the person's history and progress, and there was a discussion about the person's family situation. Then, there was a consensus agreement that the person was not yet ready to leave the hospital, and the staff member who received the letter was instructed to tell the patient that right now, he can't leave.

Is that the normal procedure?

MR. ROTH: I object. First of all, you are doing the testifying about a conference which we haven't established whether Dr. Armstrong was part of.

(119) Secondly, if you want to testify, we can put you on the stand.

Thirdly, as far as the information goes, as far as I can gather, is strictly hearsay, and based on only part.

Now, if you want to ask Dr. Armstrong about the procedure that is utilized, you may do so.

MR. FERLEGER: Your objection is noted.

BY MR. FERLEGER:

Q. (Continued) Is that procedure that which is typically followed?

A. I think, as I previously stated, Mr. Ferleger, in dealing with children, particularly disturbed children which we are speaking of, one cannot have a typical procedure. There are general cases, but actually, there are many exceptions as well.

Q. The procedure I described, is that one which—

MR. ROTH: I object to that question, and again, because there has been no foundation laid appropriately in order—

MR. FERLEGER: Depositions don't require foundations.

MR. ROTH: We are questioning and (120) cross-examining Dr. Armstrong according to law, and accordingly I advise you with regard to questions and answers that may be asked, if the proper foundation is not laid for a question then it obviously is of no matter whatsoever. If you want to ask about the procedures, fine. If you want to ask Dr. Armstrong to be a little more help to you, you can ask if she is aware of this particular meeting, according to her personal knowledge. I do not want you to mislead her since I do not know for a fact that the actual situation which you allegedly stated has occurred, and asking her whether that procedure is a uniform procedure is questionable. I have no basis of knowing the validity of that conference per se.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, assuming hypothetically the procedure I described happened as I described it, is that one of the procedures for dealing with such a notice, that your staff follows?

A. Is it one of the procedures?

Q. Yes.

A. Hypothetically, okay.

(121) Q. Assuming the facts I stated are correct, is that one of the procedures that your staff follows?

A. That's one of the procedures. There is, however, and I would prefer to elaborate for you, an additional and more useful one, which is in accordance with our major purpose of being here, and that is what regards the child's best interest. As you are well aware, any effective treatment service is continually re-evaluated and reformulated. The therapeutic community has a general meeting wherein persons requesting those passes for brief periods of time and discharges are brought up. The patients themselves—the patient's consensus is noted for the central community, who then meet with the Adolescent Service and the staff gives their opinion. It is to be noted that the staff may agree to the patient's recommendation, however, in general, a consensus agreement is attempted to be made. So that is the most general procedure than the one you stated.

Q. What if the professional staff feel it is not in the best medical interests and the—

A. I would disagree with you: medical interests. I would say the best interests of the child.

Q. If the professional judgment about the best interest of the child conflicts with the community's (122) recommendations, then you would feel obliged to agree to that suggestion?

A. That's the truth. However, to date, that has not happened.

(Discussion off the record.)

BY MR. ABRAMSON:

Q. With reference to Mr. Roth's question concerning the follow-up—all of the procedures which take place while a young person is at Haverford, I notice in particular, with reference to Miss Vicki Mathews, in the summary prepared for her, there is reference made to this continual evaluation and coordinated efforts. In particular, I notice reference is made to the recommendation concerning Devereux School for this patient.

A. Yes.

Q. And my question is—I don't see it here on this summary—do you recall if the patient, Vicki Mathews, expressed any feelings as to her opinion of Devereux School being a boarding school?

A. Yes, I recall, specifically, Vicki Mathews' opinion. Victoria Mathews is one of the patients that fits the category of being non-volitional on occasions, and on other occasions she would admit to myself and Dr. Rosen that she had problems, and on other occasions, (123) she had not, and therefore, resisted any additional psychiatric care. As you can see by her record, she had been through both Irving Schwartz Institute and the Philadelphia Child Guidance Clinic before she reached us. This is a particularly difficult individual to handle, so that the recommendation for a private facility was made more on the basis of this being something that the patient and her family could accept, rather than feeling that our facility was incapable of handling her.

BY MR. FERLEGER:

Q. Where is Devereux School?

A. Devereux School is a multitude of schools. The main office is in Devon.

Q. Is it in Pennsylvania?

A. One is in Pennsylvania. One is in Massachusetts. One is in Connecticut, and one is in California, and one is in Texas.

Q. Do you know which branch Vicki is in?

A. Yes. As general director and director of that Adolescent Service of which we speak, it becomes necessary to deal with directors of similar residential settings.

Q. Can you tell me?

(124) A. Their recommendation was that she go to Texas, and that is indeed where she went.

Q. Do you know what town?

A. Victoria.

Q. Would you call Vicki Mathews a non-volitional patient?

A. At times.

Q. Is Mark Weand a non-volitional patient?

A. At times.

Q. And what about Leslie Levine?

A. At times.

Q. And Kevin Bartley?

A. At times.

Q. And what about Steve Gentile?

A. He was Dr. Hammer's patient, and his opinion is that he was severely psychotic and not competent to exercise judgment, and my comment is I feel his objection is one that you cannot take heed to. His objection is not realistic.

Q. Do I understand that he has made objections, but because of the medical factors you mentioned, you don't feel they have substance?

A. That's correct.

MR. FERLEGER: I have no further (125) questions.

Recross-Examination

BY MR. ROTH:

Q. Dr. Armstrong, now, we have been talking about objections, and I only have one question with regard to these objections. What is the nature of these objections? Are some of them inconsistent one day or they are objecting the next day, or complaining, or are they up and down, if you will, like a yo-yo, objecting one day, and something where they are objecting the next day? Do you have an instance of this sort with regard to that type of objection? Are these types of objections consistent and repeated?

A. Yes and no. Some indeed are reflections of the child's ambivalence toward their illness, such as Kevin Bartley, and Vicki Mathews, and Mark Weand. One day they feel they can handle the problems themselves. Then when confronted with their own behavior, such as Mr. Weand's drug taking or Miss Mathew's suicide gestures, such as lacerating their wrists, their behavior is difficult to deny and the patient acknowledges the presence of his problems and has some psychiatric difficulty. In other instances such as the case of (126) Mr. Burns, who is in under 406, his diagnosis is that of personality disorder. Without going into the nature of such a diagnosis, it allows for consistent repetitive resistance toward any communication and resistance toward being hospitalized.

Q. Dr. Armstrong, with regard to the number of individuals that you have in your institution, is your specific program running at full capacity?

A. Almost full capacity.

Q. Is there a great turnover in terms of your institution wishing to release juveniles once they have attained their prospective or whatever professional terms you utilize?

MR. FERLEGER: Objection. A great turnover with regard to the institution's desires?

BY MR. ROTH:

Q. (Continued) I said: a great turnover in the number of patients, juveniles.

A. Again, I would have to answer you that with Dr. Smith's research department, we are in the process of compiling adequate statistical data which I haven't currently been able to get compiled. I can't give you figures of our average length of stay or discharge and admission rate. All I can tell you is that some patients (127) stay for two or three weeks. Some stay for several months. Their lengths of stay are based on their need for hospitalization.

BY MR. FERLEGER:

Q. In the ambivalence toward hospitalization, asking to leave one day or objecting one day, and not the next, that is true of adults as well, isn't it?

MR. ROTH: Objection.

A. Some, I would say.

Q. Is it true of some adults?

A. Yes. One cannot generalize about any statement regarding the psychiatric status of one individual.

Q. It is true of some adults and some juveniles?

BY MR. ROTH:

Q. With regard to ambivalence, is ambivalence precipitated by the condition of the patient?

A. Yes.

MR. ROTH: Thank you.

MR. FERLEGER: I have nothing else.

(Witness excused.)

(Oral examination concluded)

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(128)

CERTIFICATION

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the oral examination in the above cause, and that this copy is a correct transcript of the same.

Patricia M. Kosmalski

I have read the foregoing transcript of testimony given by me in the above matter, and hereby certify that it is true and correct to the best of my knowledge and belief.

Witness' signature

(129)

EXHIBIT A

CLASS ACTION SUIT

Name	*Age*	*Commitment*	*Assigned*
Bartley, Kevin	16	403	Dr. Armstrong
Baer, Tim	17	406	Dr. Rosen
Cross, John	17	403	Dr. Rosen
Carrelli, Suzanne	16	403	Dr. Armstrong
Clark, Beatrice	13	403	Dr. Lustig
Geiger, Deborah	16	403	Dr. Kratsa
King, Michael	14	403	Dr. Rosen
Edwards, Elizabeth	15	403	Dr. Armstrong
Gallagher, Mary Lou	15	403	Mrs. Parrish
Gentile	17		Dr. Hammer, Ellen, [Illegible]
Golden, Sally	14	403	Dr. Armstrong
Hutchins, Judy	17	403	Dr. Lustig
McCauley, Mary Ellen	16	403	Dr. Armstrong
Pollock, Nick	17	406	Dr. Armstrong, Bob Schoenhultz
Mosco, Ben	16	403	Dr. Hammer, David Brosell
Hockenberry, Tom	15	403	Dr. Hammer, Kathy Olsen
Thompson, Terry	18.9	403	Dr. Lawson
Brehm, Nancy	18	403	Dr. Armstrong
Moss, Allen	16	403	Dr. Kratsa, Kathy Olsen
Graber, James	17	405	Dr. Kratsa, David Brosell

Name	Age	Commitment	Assigned
Rhinehart, David	16	408	Dr. Kratsa
Schriber, Elizabeth	14	408	Dr. Kratsa
Burns, Richard	17	406	Dr. Lustig, Bob Schoenhultz
Barnett, Willard	15	403	Dr. Kratsa
Vantine, Michael	15	403	Dr. Hammer
Osbourne, Sue	16	403	
Parmet, David	16	403	
Cutilli, William	17	403	
Jenkins, Anita	16	408	Dr. Wochiehowski
(130) Willett, Stephen	16	408	Dr. Kratsa
Taylor, Thomas	14	403	Dr. Lustig
Saunders, Peggy Ann	17	403	Dr. Rosen
Lucas, Walter	18.5	403	

(131)

EXHIBIT B

NAME: Baer, Timothy

AGE ON ADMISSION: 14 BIRTHDATE:

COMMITMENT: 1. Date on original and present: 5/15/69

2. Type on original and present: 404

3. Changes type and when: 10/16/72 406

ADMISSION: 1. Admitting Physician: Fong

2. Reasons for Admission: Homocidal & suicidal ideation. Hallucinating, phobic Ron-Rual

3. Who reported behavior: Family

DIAGNOSIS: 1. Admission Note: Schiz. childhood type

2. New Case Conference Note: Childhood schiz.

3. Discharge and date: Still in

4. Present:

PROGRESS: (Very brief summary of hospital courses; where admitted; doctor; what program; current status)

Long, stormy Hospit., mainly on closed wards; with multiple somatic complaints, physical attacks on staff, self-destructive behavior.

Presently on closed wd, on grounds, priv

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(132)

K.O.

2-21-73

NAME: Barnett, Willard, 14-6

AGE ON ADMISSION: 14 BIRTHDATE: 8-18-58

COMMITMENT: 1. Date on original and present: 1-8-73

2. Type on original and present: 403
3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: 3 wks. of truancy; 3 days of uncontrollable behavior; threatened suicide
3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Schizophrenia, simple

2. New Case Conference Note: None
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Dr. Kratza is his doctor.

Will had been transfered to Bldg. 9 once before, but apparently was not ready for an open unit & was transfered back to Bld. 4 On 2-20-73 he was transfered back to Bld. 9.

He is involved in O.T., A.T., RT & 2 group Tx.

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(133)
KO
DATE: 2-22-73

NAME: KEVIN BARTLEY

AGE ON ADMISSION: 15 BIRTHDATE: 11-4-56 PRESENT AGE: 16-3

COMMITMENT: 1. Date on original and present: 11-30-71
2. Type on original and present: 403
3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Ivins

2. Reasons for Admission: Transfer from ESSH, temper outbursts, difficult to control
3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Organic Brain Syndrome with epilepsy. Personality disorder: explosive personality

2. New Case Conference Note: Explosive personality disorder with epilepsy.
3. Discharge and date
4. Present: On Short Term Leave since 11/23/74

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status.)

Kevin is on short term leave, attending the school program on the Hospital grounds.

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(134)
2/15/73

NAME: Burns, Richard

AGE ON ADMISSION: 17 BIRTHDATE: 12/18/55

COMMITMENT: 1. Date on original and present: 1/29/73; 2/2/73
2. Type on original and present: 406; 406
3. Changes-type and when:

ADMISSION: 1. Admitting Physician: Streker
2. Reasons for Admission: drug abuse & incorrigibility
3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: adjustment reaction of adolescence
2. New Case Conference Note: same.
3. Discharge and date

4. Present: unsocialized aggressive reaction of adolescence 308.4

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg 9 for evaluation. Assigned to Dr. Lustig. Individual & family sessions. No medications. Evaluation continuing.

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(135)
K.O.
2-21-73

NAME: Brehm, Nancy

AGE ON ADMISSION: 17 BIRTHDATE: 1-12-55

COMMITMENT: 1. Date on original and present: 8-9-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: Pt excluded from mothers home; previous drug use; previous admission to this hospital

3. Who reported behavior: Pt

DIAGNOSIS: 1. Admission Note: Adolescent adjustment Rx

2. New Case Conference Note

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Nancy is currently enrolled in the drug program on 1 No. Dr. Zal is her doctor. She is in the school program.

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(136)
K.O.
Date: 2-22-73

NAME: Carrelli, Suzanne

AGE ON ADMISSION: 16 BIRTHDATE: 4-16-56 Present Age: 16.10

COMMITMENT: 1. Date on original and present: 11-10-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Felix

2. Reasons for Admission: Suicidal ideation; chaotic family; has

3. Who reported behavior: Pt

DIAGNOSIS: 1. Admission Note: Schizophrenia, simple type with depressive features

2. New Case Conference Note

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Sue is a pt of Dr. Armstrong in Bld. 9. She is involved in the school program, and has group therapy 2 times a week. She goes home on weekends.

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(137)
Date: 2/15/73

NAME: Clark, Beatrice

AGE ON ADMISSION: 13 BIRTHDATE: 4/27/59 Present Age: 13

COMMITMENT: 1. Date on original and present: 1/16/73

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Armstrong

2. Reasons for Admission: episodic drinking, running away, & stealing "catatonia"

3. Who reported behavior: Mother & BSU psychologist

DIAGNOSIS: 1. Admission Note: deferred

2. New Case Conference Note: 308.4

Discharge and date

4. Present: unsocialized aggressive reaction of adolescence 308.4

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg 9, assigned to Dr. Lustig. Receiving milieu therapy & family therapy. Discharge anticipated soon.

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(138)

NAME: Cross John

AGE ON ADMISSION: 17y-o- BIRTHDATE: 10/9/54

COMMITMENT: 1. Date on original and present: 2/19/72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Wicoff

2. Reasons for Admission: Talking incoherently suicide threats

3. Who reported behavior: Family

DIAGNOSIS: 1. Admission Note: Schizo—Aff. Schiz

2. New Case Conference Note: Acute Schiz. Episode

3. Discharge and date: Still in

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

2 Elopements

Presently AWOL

---

(139)

K.O.

3so 2-21-73

NAME: Cutilli, Wm, 17 yo

AGE ON ADMISSION: 16 y. o. BIRTHDATE: 1-5-56

COMMITMENT: 1. Date on original and present: 1-3-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION 1. Admitting Physician: Dr. Buck

2. Reasons for Admission: Pt had been under treatment at Allentown State Hospital since Age 5. Pt can't speak.

3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Schiz., childhood type

2. New Case Conference Note: Childhood Schitz

3. Discharge and date:

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

3 so. Dr. Lawrence
Mute
In school program on 3S0
Behavior problem—irratic behavior

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(140)
K.O.
Date: 2-22-73

NAME: Elizabeth Edwards
AGE ON ADMISSION: BIRTHDATE: Present Age:
COMMITMENT: 1. Date on original and present: 11-16-72
2. Type on original and present: 403
3. Changes type and when:
ADMISSION: 1. Admitting Physician: Dr. Armstrong
2. Reasons for Admission: Suicidal gestures
3. Who reported behavior: Pt & social worker
DIAGNOSIS: 1. Admission Note: Adolescent Adjust. Rx
2. New Case Conference Note:
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Liz is a pt of Dr. Armstrong in the Open Unit Bld. 9. She in involved in the school program, & group therapy 2 x a week.

(141)
2/7/73
KO

NAME: Deborah Geiger, 16.7
AGE ON ADMISSION: 16 BIRTHDATE: 7-13-56
COMMITMENT: 1. Date on original and present: 1-17-73
2. Type on original and present: 403
3. Changes type and when: None
ADMISSION: 1. Admitting Physician: Dr. Kratza
2. Reasons for Admission: Chaos in life; multiple destructive tendencies
3. Who reported behavior: Parents
DIAGNOSIS: 1. Admission Note: Reactive disorder
2. New Case Conference Note: None
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Involved in the school program, group therapy 2 x a week. Dr. Kratza is her doctor.
Family Fx.
Mostly cooperative.
No meds

---

(142)

NAME: Gallagher, Mary Lou
AGE ON ADMISSION: 15 BIRTHDATE: 9/15/57

COMMITMENT: 1. Date on original and present: Original 8/28/72 Present 10/26/72

2. Type on original and present: Original 403 Present 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Wic-off

2. Reason for Admission: Rebellion, aggressive behavior. Runaway, threatening to take drugs. Refusing out-patient care.

3. Who reported behavior: Father, Mr. Joseph Gallagher Mother, Mrs. Gallagher

DIAGNOSIS: 1. Admission Note: unsocialized agressive reaction of adolescence.

2. New Case Conference Note:

3. Discharge and date 2/12/73 AMA

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Marylou was a pt of Dr. Armstrong in the Open Unit. While there, she had at least 2 serious episodes of drug taking, and 2 elopements, which necessitated her transfer to the closed unit.

She was admitted into the drug program at HSH on 2/6/73 on 2/12/73 she was discharged AMA.

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(143)

Date: 2-22-73

NAME: Steve Gentile

AGE ON ADMISSION: 17 BIRTHDATE: 3-20-54 Present Age: 18.11

COMMITMENT: 1. Date on original and present: 8-24-71

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Ivins

2. Reasons for Admission: Pt is extremely violent, striking family, biting father.

3. Who reported behavior: Father

DIAGNOSIS: 1. Admission Note: Schizophrenia, acute undifferentiated

2. New Case Conference Note: Schiz., Chronic undifferentiated

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt is under care of Dr. Hammer. At present he is in the closed unit. He has been in the Open unit at times, but became increasingly bizare & became assaulting to his father the last time he was in the Open unit.

---

(144)

2/7/73

K.O.

NAME: Tom Hockenberry, 15.8

AGE ON ADMISSION: 15 BIRTHDATE: 5-28-57

COMMITMENT: 1. Date on original and present: Sept 20, 1972

2. Type on original and present: 403 (original & present)

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Bluitt

2. Reasons for Admission: Tom had been on Qualude, Marijuana, LSD, History in Montgomery County Home of overtly psychotic behavior and a bizare suicide attempt. He had threatened and assaulted his father.

3. Who reported behavior: Pt and Father

DIAGNOSIS: 1. Admission Note: Drug dependence

2. New Case Conference Note: Adolescent & Drug Rx accompanied by mixed drug abuse

3. Discharge and date

4. Present: Same

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Tom was admitted to 4so. He was assigned to Dr. Hammer, of the adolescent service. He was transferred to Bld. 9 Sept. 29, 1972. Oct 9 he was transferred back to Bld. 4 for acting out behavior.

Oct 25 he was transferred to Bld. 9.

11/1—Tom eloped—on return was placed on 4so.

2/5—Trans to Bld 9

Attends school program, music therapy, 2 group therapies/wk. Takes Meds

---

(145)

Date: 2/15/73

NAME: Hutchins, Judy

AGE ON ADMISSION: 17 BIRTHDATE: 9/20/55 Present Age: 17

COMMITMENT: 1. Date on original and present 11/27/72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Wendell

2. Reasons for Admission: bizarre behavior

3. Who reported behavior: Parents, BSU

DIAGNOSIS: 1. Admission Note: R/o Acute Schizophrenic reaction

2. New Case Conference Note: Acute schizophrenic reaction 295.4

3. Discharge and date: 295.4 2/8/73

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg 4. Rx'd with Phenothiazines; Accepted to Adolescent Service to Dr. Lustig Transferred to Bldg 9. Rx'd with milieu, family & pharmaco-therapy.

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(146)

Feb. 7, 1973

NAME: Golden, Sally

AGE ON ADMISSION: 14.8 BIRTHDATE: 4-13-58 Present Age: 14.10

COMMITMENT: 1. Date on original and present: 12-15-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Coin C. Lindquist, M.D.

2. Reasons for Admission: Suicide attempt, ideation.

3. Who reported behavior: Pt.

DIAGNOSIS: 1. Admission Note: 1 Psychoneurotic depression of suicidal ideation 2. Adol. Adj Rx with hysterical feature

2. New Case Conference Note:
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to #4 12.15
Transferred to # 9 12.18
Dr. Armstrong
Attended School, O.T., A.T., Gp.T., Rt. until started school full day.
Family Tx
Takes meds
No problem

---

(147)
2/7/73
K.O.

NAME: Micheal King, 14.7

AGE ON ADMISSION: 14 BIRTHDATE: 7-3-58

COMMITMENT: 1. Date on original and present: 11/2/72

2. Type on original and present: 403
3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: Mike stayed in his room at home for 43 days, refused O.P. help; has severe school phobia & refused to attend school

3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Schizoid Personality, Severe 301.2

2. New Case Conference Note: Schizoid personality with school phobia
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Mike was admitted directly to the adolescent unit. He is involved in school here, and 2 group Tx a week. He is a pt of Dr. Rosen. He is cooperative on the unit, but the staff feels that his will be a long stay.

Cooperative.
Takes meds

---

(148)
K.O.
3so 2-21-73

NAME: Lucas, Walter 19.3 y.o.

AGE ON ADMISSION: 17. BIRTHDATE: 10-30-53

COMMITMENT: 1. Date on original and present: 7-31-70 8-29-72

2. Type on original and present: 416 402
3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Newman

2. Reasons for Admission: Transfer for ESSH retardation, "schiz, process" Chronic brain syndrome

3. Who reported behavior: Paul Goldberg of ESSH

DIAGNOSIS: 1. Admission Note: Mental retardation with Psychosis R/o Schiz, latent type

2. New Case Conference Note: Moderate mental retardation

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

24 times in seclusion from Aug. 13, 1970 to 6-8-72

Pt on 3S—Dr. Lawrence

In the School Program on 3So

He is a behavior problem—Impulsive

---

(149)

D.B.

Date: 2/21/73

NAME: McCauley, Mary Ellen

AGE ON ADMISSION: 16 BIRTHDATE: 2/26/56 Present Age: 16.11

COMMITMENT: 1. Date on original and present 11/7/72

2. Type on original and present: 403-403

3. Changes type and when:

Admission: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: Seceral & Alcohol Overdose—Temper Tantrums and rebellious behavior at home reaction of adolescence.

3. Who reported behavior: Dr. Fitti, BSU III; Parents

DIAGNOSIS: 1. Admission Note: Adjustment reaction of adolesence.

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Mary Ellen is a pt of Dr. Armstrong. She is enrolled in the school program, has group Tx 2 times a week. She has individual therapy with Mrs. Thompson.

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(150)

NAME: Mosco, Benjiman

AGE ON ADMISSION: 14yrs. BIRTHDATE: 12-20-57 (15.2 yrs.)

COMMITMENT: 1. Date on original and present: 5-15-72

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Mary P. Siegel, M.D.

2. Reasons for Admission: Behavior problem: Sexual acting out, foul language, physically abusing step-mother, running away, crashing family car, drugs.

3. Who reported behavior: Step-mother, Gandenzia Hacek

DIAGNOSIS: 1. Admission Note: 308.4, Unsocialized aggressive reaction of adolescence.

2. New Case Conference Note. Same

3. Discharge and date: 11/22/72—STL; Renewed 12/22/72

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt. admitted to closed unit on 5/15/72 and was transferred to the open unit on the Adolescent Service on

5/23/72 under the care of Dr. Hanno. Received individual & group therapy and was enrolled in the special education school program.

Family was seen in 10/72, 11/72, & 12/72 in family therapy with Family Service. (Media). Presently pt. is an STL—to be discharged as soon as father comes to hospital to sign papers.

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(151)
2/7/73
E L

NAME: Moss, Alan
AGE ON ADMISSION: 15 yrs BIRTHDATE: 3-24-57 (15.11 yrs)
COMMITMENT: 1. Date on original and present: 1-10-73
2. Type on original and present: 403
3. Changes type and when: None
ADMISSION: 1. Admitting Physician: G. P. Kratsa, MD.
2. Reasons for Admission: Depressed and suicidal
3. Who reported behavior: Patient
DIAGNOSIS: 1. Admission Note: Depressive Reaction
2. New Case Conference Note:
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Patient admitted to Closed Unit (5s) on 1-10-73 and was transferred to Bldg 9 on 1-13-73, Adolescent Service under care of Dr. Kratsa. Attended program on Unit, OT,

Art Therapy, Recreation Therapy & Group Th. Was entered into School Program Bldg 2 on 1/24/73. Family was seen 1/13/73; 1/19/73; 2/2/73 in Family Therapy. Further Neurological Studies are indicated and have been scheduled.

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(152)
K.O.
(IN) 2-21-73
NAME: Osbourne, Sue 16.4
AGE ON ADMISSION: 16 BIRTHDATE: 10-7-56
COMMITMENT: 1. Date on original and present: 1-22-73
2. Type on original and present: 403
3. Changes type and when:
ADMISSION: 1. Admitting Physician: Dr. Wicoff
2. Reasons for Admission: Taking I.V. methadrine for 2 yrs
3. Who reported behavior: Pt.
DIAGNOSIS: 1. Admission Note: Habituation —Methadrine with recent hallucinations auditory & visual
2. New Case Conference Note: Adjustment Rx of Adolesc. with drug abuse.
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt admitted to drug program—1 No.—Dr. Zal.
Involved in group therapies.

(153)
K.O.
2-21-73

(35) NAME: Parmed, David—16.8
AGE ON ADMISSION: 16 BIRTHDATE: 6-1-56

COMMITMENT: 1. Date on original and present: 6-5-72
2. Type on original and present: 403
3. Changes type and when:
ADMISSION: 1. Admitting Physician: Dr. Siegel
2. Reasons for Admission: Transfer from ESSH —Childhood Schiz.
3. Who reported behavior: ESSH—Bill Scott
DIAGNOSIS: 1. Admission Note: Childhood Schiz.
2. New Case Conference Note: Same
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)
3 So—Dr. Lawrence
In school program on 3 So
Behavior problem—Aggressive, impulsive

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(154)
2/7/73

NAME: Pollock, Michael (Nick)
AGE ON ADMISSION: 16 BIRTHDATE: 12-18-55 Present Age
COMMITMENT: 1. Date on original and present: 11-2-72

2. Type on original and present: 406
3. Changes type and when:
ADMISSION: 1. Admitting Physician: David N. Wicoff, M.D.
2. Reasons for Admission: Patient describes dissociative state while stealing a car and breaking into another. Several past suicidal attempts. Has heard voices & has had visual hallucinations. Judgment inmature impulsive. Suspiciousness
3. Who reported behavior: Patient.
DIAGNOSIS: 1. Admission Note: Border line Psychosis w/depression
Drug Habituation—LSD
2. New Case Conference Note: Schizoid personality, severe
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status.)
Institutionalized since 5 years old.
11-8-72 refused A.M. MEDS "doesn't want it"
11.14 needed additional meds for agitation.
11.16 off grounds returned by guards & nurses.
11-25 refused AM MEDS
12.6 agitated & fearful, banging hand on wall, threatening, talking of hurting himself and dying.
Transfer to Bldg 4
12.8 refused same meds
12.28 pt. reported pains in hand & wrist from agitation & hitting a window
12.28 refused meds
1.1.73 broke glass in candy machine in lobby

1.2 refused all meds

1.3 extreme agitation—put fist & arm through window—cut's

1.5 reported severe headache and difficulty breathing from "anxiety"

1.7 reported extreme depression over weekend & drug usage

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(155)

1.10 scratched arm with razor in suicidal gesture upon postponement of an appt.

1.22 stated he was "losing control"—requested meds.

1.29 reports LSD usage over weekend—upset by flashbacks—

Transfer to Bldg 4

1.30 refused AM meds

11 31 Return to Bldg 9

2.4 Pt. eloped

2.6 returned by Mrs. Iverson—laceration of left wrist, self-inflicted

To Bldg 4

2-12 Return to Bldg 9—

—Pt. asks consistantly for help but responds minimally to attempts by the staff.—

MED Feb

Prolixin 5 mgm QID

Donnatal tab + TID

Multivits + OD

Artane + mgm QID

Peotafrave 50 mgm TID [triangle] QID

Benadryl (elix) 100 mgm H.S.

Thorazine 10 mgm PRN (for Flashbacks or Hallucinations)

Mellaril 75 mgm PRN (agitation)

Calfeoget tab (headache)

Tigan 250 mgm PRN

D/C Thorazine 50 mgm Im

PROGRAM

School in bldg.—daily

Art Therapy—daily

Recreation. Therapy—daily

Group Therapy—2x weekly

Indiv. Therapy—2x weekly

Counseling (Brassell)—On Demand

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(156)

NAME: Saunders, Peggy Ann

AGE ON ADMISSION: 17 3/15/55 BIRTHDATE: 3/10/55

COMMITMENT: 1. Date on original and present: 2/2/73

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: Admitting Physician: Wicoff

2. Reasons for Admission: Retarded, Brain damaged management [Illegible]

3. Who reported behavior: School

DIAGNOSIS: 1. Admission Note: Mental Retard Explosive BEHAV

2. New Case Conference Note: C 5

3. Discharge and date C 5

Present: Same

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Closed Ward.

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(157)

Date: 2/15/73

NAME: Taylor, Thomas

AGE ON ADMISSION: BIRTHDATE: 5/27/58 Present Age: 14

COMMITMENT: 1. Date on original and present: 2/2/73

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Gold

2. Reasons for Admission: Suicidal ideation

3. Who reported behavior: Children's Cottage

DIAGNOSIS: 1. Admission Note: Adjustment reaction of adolescence with suicidal ideation.

2. New Case Conference Note: Schizophrenia, latent type 295.5

3. Discharge and date

4. Present: 295.5

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg. 4. Assigned to Dr. Lusig. Rx'd with phenothiazine, resulting in rapid reconstitution. Transferred to Bldg 9. Eloped. Transferred back to Bldg 4.

(158)

2/7/73

NAME: Terence Thomson Present Age: 18.9

AGE ON ADMISSION: 17.4 BIRTHDATE: 3-3-54

COMMITMENT: 1. Date on original and present: 8/20/71 2/7/73

2. Type on original and present: 403 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: B. H. Armstrong, MD.

2. Reasons for Admission: Destructive to house breaking furniture; impaired judgment, pre occupation with exhibitionistic sex, threatening sexual & physical to mother.

3. Who reported behavior: Parents.

DIAGNOSIS: 1. Admission Note: Undiff. Schiz. Reaction 295.99 ~~Mental Retardation 310~~

2. New Case Conference Note: Passive—aggressive personality. Mental retardation, Mild. Ampathy [Illegible]

3. Discharge and date

4. Present: Same

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted by Dr. Armstrong. On Adolescent Program, School Program, group therapy, family counseling. Cooperative, friendly, gets along with peers, and staff. Very inactive, even babyish when with his parents. Pt. has done well in school, adjusted well to Adolesc. program. Goals include getting into some sort of job training (eg. Bakery), later get job, live at home. Needs to be

communicative, responsible, grown-up in relationship with his parents.

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(159)
K.O.
2-21-73

NAME: Vantine, Michael 16. OY.O.

AGE ON ADMISSION: 15 y.o. BIRTHDATE: 2-7-57

COMMITMENT: 1. Date on original and present: 8-24-72

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: Transfer from Friends Hospital due to lack of funds; history of barbiturate dependency, seizures. Suicidal attempt 6 wks prior to admission.

3. Who reported behavior: Child case worker

DIAGNOSIS: 1. Admission Note: Schiz, latent type; adjustment Rx of adolesence with depression; minimal cerebellar dysfunction

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

9-18-72—cut arm, not seriously

11-8-72—suspected of selling drugs at school

11-13-72—attempted to hang himself

12-11-72—stole medications fr 9So medication cabinet

12-11-72—possible drug overdose

12-26-72—drinking, & found with pills in his possession

Dr. Hammer's pt. when not in Bld 9 he is a pt of 4so

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(160)
February 21, 1973

NAME Graber, James

AGE ON ADMISSION: 17 BIRTHDATE: 4/26/55

Present Age: 17 yrs.

COMMITMENT: 1. Date on original and present: 2/2/73

2. Type on original and present: 405-403

3. Changes type and when: Changed to 403 on 2/7/73

ADMISSION: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: Valium Overdose, suicidal ideations, assaultive behavior in the home.

3. Who reported behavior: Mrs. Virginia Owen (Child case worker) Father Francis Serick (Principal of Msr. Bonner H. S.)

DIAGNOSIS: 1. Admission Note: Depressive Reaction.

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt. evaluated & accepted by adolescent Service. Transferred to open building 2/2/73 under care of Dr. Gus Kratsa. Eloped 2/13/73. Current on U.A.

(161)
Date: 2/14/73

NAME: Anita Jenkins

AGE ON ADMISSION: 16 BIRTHDATE: Present Age:

COMMITMENT: 1. Date on original and present: 405—11/29/72

2. Type on original and present: 405—408 12/5/72

3. Changes type and when: 405—408

ADMISSION: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: charges of assault & battery while at Sleighten Farm.

3. Who reported behavior: Sleighten Farm

DIAGNOSIS: 1. Admission Note: 1. Mild Mental Retardation 2. Antisocial personality

2. New Case Conference Note: Unsocialized aggresgressive vxn of adolescence

3. Dicharge and date

4. Present: Unsocialized aggressive vxn of adolescence

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to 5N—Dr. Wojcrechosk

Acute Treatment Unit—I.C.U.

Program: individual therapy, school tutoring, group therapy (5N), remotivation group, occupational therapy

Current status—controllable aggressive tendencies,, but tends to be provocative with vulnerable, Individual She attends school and group, but is easily discouraged and feels worthless. She goes weekly for weekend visits at home.

(162)
K.O.
2-22-73

NAME: Rhinehart, David 16.4 y.o

AGE ON ADMISSION: 16yo BIRTHDATE: 10-3-56

COMMITMENT: 1. Date on original and present: 1-11-73

2. Type on original and present: 408

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: Court—Stealing cars

3. Who reported behavior: Parents

DIAGNOSIS: 1. Admission Note: Deferred

2. New Case Conference Note: Non psychotic organic brain syndrome antisocial personality

3. Discharge and date

4. Present:

PROGRSS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

David had been in the adolescent service under Dr. Kratsa's care in the Closed Unit. He was transferred to the open unit. While there he stole a car. He was transferred to the Closed Unit again. ~~He has since had a Court hearing at which time~~

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(163)
K.O.
2-22-73

4N

NAME: Schriber, Elizabeth 14.3

AGE ON ADMISSION: 14 BIRTHDATE: 11-25-58

COMMITMENT: 1. Date on original and present: 1-25-73

2. Type on original and present: 408

3. Changes type and when: extended indefinitely 2-4-73

ADMISSION: 1. Admitting Physician: Dr. Wic-off

2. Reasons for Admission: 10 day evaluation at request of court

3. Who reported behavior:

DIAGNOSIS: 1. Admission Note: Adjustment Rx of Adolescence; suicide attempt and ideation

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt is on 4No, Adolescence service. Dr. Kratsa is her doctor. She is enrolled in VAS.

She will be transferred from the Closed unit to the Open unit shortly.

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(164)

K.O.

2-23-73

(4S)

NAME: Willett, Steve, 16.9 yo

AGE ON ADMISSION: 16 BIRTHDATE: 4-26-56

COMMITMENT: 1. Date on original and present: 1-23-73

2. Type on original and present: 408

3. Changes type and when: Extention on 2-2-73 for 30 days per Judge Reed

ADMISSION: 1. Admitting Physician: Dr. Wic-off

2. Reasons for Admission: Violation of probation

3. Who reported behavior: Judge Reed (?)

DIAGNOSIS: 1. Admission Note: Runaway rx of adolescence (?)

2. New Case Conference Note: Adolescent adjust-ment rx

R/o Drug dependence

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Steve is a pt of Dr. Kratsa on 4So.

Adolescent service, locked building.

Court hearing 2-21-73—recommendation to be sent to St. Gabriel.

(165)

EXHIBIT C

HAVERFORD STATE
LEVINE, Leslie
9645 1

SUMMARY

This is the first Haverford State Hospital admission for this 15 year old, white, single, 10th grade student admitted here 10-11-72 on a 403 commitment signed by her mother. The patient's mother and her two sisters were seen along with the patient by Dr. Arenowitz at Base Service Unit III for 9 sessions during the months prior to admission because of family quarrels. On the day of admission the patient felt as she stated "closed in" by the mother and she threatened the mother with a kitchen knife. The mother contacted Dr. Arenowitz who recommended hospitalization at Haverford State Hospital.

The patient's parents have been separated since the patient was approximately 5 years of age. Patient did not see her father again until March, 1971. During the past 2 school years Leslie and her mother have had battles over everything Leslie has wanted to do. Subsequently, Leslie began having problems in school. In an effort to help her finish the school year she was sent to Florida from March to June, 1971, and February to June, 1972, to live with her father and step-mother and complete the school year. Leslie idolizes her father although the period spent with him and her step-mother were not idealic because of the step-mother making her do domestic duties.

On admission here the patient was admitted to a closed ward and evaluated by the Adolescent Service on

October 12, 1972. She was than transferred to the open adolescent building where she remained until discharge. She was placed on Stelazine 2 mgs. tid until November 13th when psychiatric medications were discontinued. While on the open ward she participated in group therapy twice a week, was assigned a counselor and seen individually by either Dr. Armstrong or Dr. Rosen as was needed. She also attended school regularly. She and the family were seen by Dr. Lustig on a regular basis in Family Psychotherapy.

New Case Conference held on October 16, 1972, revealed a diagnosis of Adolescent Adjustment Reaction. Psychological testing revealed a 15 year old girl functioning within the average range of intelligence with indications that her poor school achievement had been due to basic difficulty in handling specific facts. She revealed a tendency to overlook details. She seen as a highly infantile individual who responded hostily to the environment and who used all her resources to contain her negative feelings. It was felt that at times of stress, particularly when related to quarrels with her mother, acting out behavior was highly likely.

Electroencephalogram, neurological and routine lab studies were all normal. Routine physical examination was normal.

(166)

On the open ward patient remained rather withdrawn, socializing minimally with the patients and staff. If an incident occurred, she seemed always to be present but denied any active participation in the scene. Finally towards the second week in October she became involved with another patient in a number of incidents in which

she broke minor rules on the floor, became verbally abusive, began to tease another patient and she was transferred to the closed unit on October 18th. On the closed ward she soon settled down, attending school and was given limited ground privileges. She was transferred back to the open ward on October 23rd where she remained on no medication until her discharge. Both the patient and her mother wish the patient to live with her father in Florida and complete the school year as done in the past. Both agreed to our recommendation of individual therapy while living with the father in Florida. Because of the chaotic family situation in Florida discharge had to be delayed until its resolution. When this was done the patient was discharged on 11-16-72.

DIAGNOSIS: Adolescent adjustment reaction.

RECOMMENDATIONS: Patient to live with father in Florida and continue out-patient and individual therapy in Florida.

Howard Rosen, M.D.

HR/dmn/1s

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(167)

HAVERFORD STATE HOSPITAL
WEAND, Mark

SUMMARY:

PSYCHIATRIC HISTORY:

This 15 year old white boy was admitted to HSH on 6-24-72 under a 402 commitment following transfer from Osteopathic Hospital where he had remained overnight. His admission there was precipitated by ingestion of approximately 8 Valium and possible glue sniffing. While

under the influence of drugs the patient tried to kill his uncle with a knife. At the time of his admission to HSH he was still intoxicated from the use of drugs and was extremely hostile; at that time it was not possible to perform an adequate mental status examination. Subsequent mental status the following day revealed the patient to be oriented in all spheres and to exhibit no evidence of psychosis. However marked impulsivity and immature judgment were present.

Past psychiatric history included the patient having been placed on probation after a drug abuse charge and a court evaluation on February 20, 1972. Mark has a 1½ year history of underacheiving, truancy and drug abuse.

Psychological Evaluation was done by the court on February 20, 1972 and revealed a full scale I.Q. of 82 (the dull normal range of intelligence.) It was noted that he had impaired concept formation.

His parents were divorced in 1960. His mother lives with an unmarried brother and sister and the maternal grandmother. Mark has a 17 year old sister.

New Case Conference was held on July 3, 1972; diagnosis at that time was 309.14 Non-psychotic organic brain syndrome, Valium and others, and 306.4 Unsocialized aggressive reaction of adolescence.

During the month of July the patient was seen by Dr. Rashkis in group therapy twice per week. On 7-12-72 he was transferred to Adolescent Service Open Unit. He received no medication other than Benedryl 100 mgmh.s. Subsequent laboratory tests, EEG and Neurological Examination were all within normal limits. On the open unit the patient attended group therapy twice a week and was seen individually once a week by Dr. Armstrong.

After approximately 3 weeks it was decided in Staff Conference that the patient's family should be seen in family therapy. This was begun in early August on a once a week basis. The patient's aunt, uncle and mother were included in most sessions. In one session the sister came, (168) and in one other session the maternal grandmother came.

Due to complaining of being depressed the patient was placed on Tofranil 25 mgm t.i.d. for 3 days then Tofranil 50 mgm t.i.d.. Tofranil was discontinued on 8-21-72 with no effect at that time. Patient was placed on Elavil 25 mgm t.i.d. for 3 days and then Elavil 50 mgm t.i.d.. On 8-10-72 the patient was transferred to 5 South Adolescent Service Closed Unit due to his having taken 3 Tuinal and having sustained an unsteady gait, slurred speech and uncontrolled behavior while in the open building. He was transferred back to the Adolescent Service Open Building on 8-14-72. The patient continued to state that he felt he was being kept in the hospital against his will and he denied that there was any problem other than his drug usage. However it was apparent from his behavior toward the staff and other patients, that there is marked passive-aggressiveness and disproportionate hostility and suspicion in dealing with others. The patient was considered appropriate for the Adolescent Program because of his personality problems, the drug abuse was judged by the staff to be symptomatic of these problems. It was the best judgment of the Adolescent Service physician that a drug treatment program per se was not the treatment choice, but the more appropriate modality was that of a milieu group. On Labor Day weekend the patient was given a weekend pass and he was given sufficient Elavil for 3 dosages a day for 4 days. He took the entire dose at one time and arrived in a comatose state back at

this hospital; he was transferred to Bryn Mawr Hospital and remained in the Intensive Care Unit for 24 hours before being transferred to the closed unit in Adolescent Therapy. Patient continued to be very angry, sullen and unreachable.

Family Therapy was continued with varying numbers of the family present. Patient continued in the Special Education School Program. He also continued in group therapy twice per week. Following the overdose of medication patient was placed on no medication with the exception of the small amount of Thorazine for agitation 25 mgm which was continued for 7 days and than discontinued. In October, family therapy consisted of the patient and his mother only, this was an attempt to allow them to break away from the mother's primary family and to live in an apartment. The patient was placed on Short Term Leave on 10-18-72. He was to become involved in out-patient therapy prior to discharge. On 10-24-72 the patient was brought back to the Adolescent Service by the police after being questioned due to false accusation of stealing. He also appeared to be on drugs and was requested to give a urine sample which he refused. He (169) then superficially slashed his wrist and was readmitted to the closed building. He was transferred back to the Adolescent Service Open Unit on 10-26-72. He was again placed on Short Term Leave on 11-1-72 with the understanding that he become actively involved in out-patient psychotherapy at B.S.U. II and to continue in HSH Special Education Program. He was on no psychiatric medication. In all, patient was seen in group therapy 28 times, family therapy 8 times and individual therapy 7 times.

BHA/dmn

Barbara H. Armstrong, M.D.

(170)

HAVERFORD STATE
GENTILE, Stephen
7100

SUMMARY

This 18 year old, white male has been a patient since August 24, 1971, when he was admitted under Section 403 (signed by parents) for his having become violent and aggressive towards his family and younger children in his neighborhood. A previous hospitalization from 12-29-70 to 4-21-71 terminated when patient was discharged against medical advice from unauthorized absence. His diagnosis at that time was—Schizophrenic Reaction, chronic undifferentiated type. At the time of admission and subsequently the patient presented with confusion, disorientation, inappropriate affect, often giggling without apparent cause, ideas of reference, unprovoked aggressive acts toward Staff and considerable degree of hostility in the form of restlessness and agitation.

Chemotherapy and a course of ECT from September-October 1971, had only marginal involvement for the patient. This examiner assumed management of Stephen's case starting in January of 1972. More reality contact and less confusion was noted in March and medication was readjusted. Patient was extremely resistant to being transferred to the open unit of the Adolescent Service. He frequently refused structure and support. The Adolescent Staff was able to maintain him in the open unit from May through continual support but only with some difficulty. Patient became confused, was involved in antisocial acting-out and fecal smearing, and was transferred to a closed unit from August 4 to October 9, 1972. He returned to the open unit after he became better able to

handle a less structured environment and after he stabilized on phenothiazines.

Since his return to the open unit, patient has been in a modified school program, receiving chemotherapy and family therapy on a weekly basis. His weekends home from Haverford State Hospital have been uneventful, although parents report patient has difficulty in socialization, stays close to the family and is uneasy when in public.

Plans are for gradual increase in patient's school program and reduction of medication to an out-patient maintenance level before discharge. The patient has required high doses of medication in order to be able to function and his improvement has been marginal until now. He is still considered incompetent, appearing confused as to his goals, lacking any insight and judgment as to his reasons for hospitalization.

Diagnosis:— Schizophrenia, chronic undifferentiated type.

Currently, the patient is placed on the following medications:— Artane 1 mg. bid, Benadryl 100 mgs. hs and Thorazine 300 mgs. qid. He has been scheduled for group therapy twice per week and individual therapy once per week. Patient has attended group therapy 33 times, Individual Therapy 16 times and Family Therapy 12 times.
CH/ frg

11/28/72

Carl Hammer, M.D.

(171)

HAVERFORD STATE
MATHEWS, Vicki
9416

SUMMARY

Psychiatric History

This is the first Haverford State Hospital admission for this 15 year old, white, 9th grade student, admitted to this hospital 8-9-72 on a 403 commitment, signed by her parents. She was brought to the hospital by the police for psychiatric evaluation with the approval of the Assistant Superintendent Dr. Phillips, after being picked up in the park in an incoherent, assaultive state along with several young men. Patient had run away from home approximately 10 days prior to admission.

The patient and her family had been seen for family psychotherapy in the Irving Schwartz Institute in 1971 and the Philadelphia Child Guidance Clinic in 1972. Family terminated both these contacts on their own because they sought individual psychotherapy for her with Dr. Curran. After several sessions the latter left for vacation. The family stated that Dr. Curran's advice was to let Vicki live away from home and check in with them periodically. She subsequently ran away and they had no contact with her other than occasionally by telephone until summoned by the police on August 9th, as noted above.

The patient has failed and repeated the 7th grade. The family states that she has a reputation as the "school tramp" and that her siblings are embarrassed by her behavior. She has been picked up by the police on several occasions although no charges were pressed. On one occasion last year she ran away to Elkton, Maryland and stayed away overnight on several other occasions. At age 3 years, Vicki was evaluated at the University of Pennsylvania for stammering. In the second grade the parents and the child were seen by Dr. Herman Staples when Vicki refused to go to school.

On initial status patient appeared as a small adolescent, oriented fully and unsteady of gait. There was much evidence of anger and hostility. She admitted trying to commit suicide while in jail (multiple scratches on both wrists and arms)—"What do I have to live for—a bunch of shit!" She admits to having abused drugs for 6 to 7 months (Quaalude and Tuinal) and said that she had 2 Tuinals that morning. Prior to this she smoked hashish and marijuana. She vented much hostility towards her family, particularly her father, "My family is screwed up. What can I do? I tried running away and it just got me in jail." In addition, the patient told her father that she had been raped the night before.

(172)

Psychological testing was done and compared to the report from the Irving Schwartz Institute (which the family was very reluctant to release to us). Based on this report, there was no evidence of a thought disorder. The patient was currently functioning on a lower average range of intelligence, giving evidence of bright, normal and even superior learning capacities, only partially utilized at the time of testing. (Negative attitudes toward school and clear deficit in school related tasks suggest this area as the focal point of much of her current difficulties.) In general, she was seen as a frightened girl, who was attempting to strike out at her surroundings in self defense.

Social Service workers' impression was that the parents have been seeking professional help since she was 3 years old. The family has been extremely critical of past professional psychiatric help and they see Vicki's problem as an individual one and not as one of the family or between the marital partners. They are very eager for placement outside of the home.

Hospital Course

Progress in the hospital.

The patient was admitted to a closed facility. For the first 48 hours she required psychotropic medication and confinement in order to help her to control herself. She remained unsteady of gait and verbally abusive. Within a few days, however, she settled down and received ground privileges.

On August 9, 1972 she claimed to have been struck by another patient while making a telephone call. She eloped from the hospital that weekend. On August 23, 1972 she was transferred to the open adolescent facility and on August 25, 1972 the family was seen to preliminarily sound them out on future planning. Mrs. Mathews, in particular, did not desire Vicki to return home. The preliminary recommendations of the Adolescent Service were conveyed to the family in that the patient needed a structured, residential school setting and should not return to the family.

Meanwhile, the patient continued on no medication; she attended group therapy on a twice a week basis; she was assigned to an individual counsellor, and was seen individually by either Dr. Rosen or Dr. Armstrong, as required.

(173)

On September 5th, the patient became increasingly agitated. She refused to go to school, which was starting that week and was quite obviously concerned about disposition. The agitation increased with a number of incidents on the ward, including threatening to elope and smoke pot so that ultimately the patient was transferred back to a closed ward on September 12, 1972. She remained there for approximately 3 days and soon calmed down and she was able to attend school from the closed building on grounds privileges, and then was returned to the open unit on September 15.

At Staff Conference in mid-September two recommendations were made—one for residential schooling, since it seemed desirable to remove the patient from the family setting because the family had been so rejecting of her and scapegoating her. In view of the patient's apparent willingness for residential placement, and necessary financial resources, a school such as Devereaux, which is a residential treatment center, was recommended to them. Secondly, if the patient's financial resources would not permit private residential placement, it was recommended that the family take the patient to court to be declared incorrigible. Three, the patient was not considered suitable for public school education because of the long history of emotional disturbance.

The patient was informed of the Adolescent Service's recommendations and the family was again consulted. Interviews were arranged at Devereaux for the family and the patient. The patient also made application to the George Junior Republic School in New York State.

On the ward the patient was started on Haldol 1 mg. tid. and Cogentin 1 mg. tid. The patient continued to

attend group and school uneventfully until the second week in October. At that time she became anxious and refused to attend certain assigned activities and became verbally abusive, breaking minor restrictions on the ward, especially harassing other patients. An attempt was made to deal with this on the open ward administratively but this failed and the patient had to be transferred to the closed ward again on 10-18-72. She remained there only a couple of days and saw that she was inappropriate in how she had acted. She was transferred back to the open ward 10-20-72 where she remained until her discharge on 11-7-72.

On admission, physical exam was unremarkable. Neurological exam was normal. EEG and routine admission studies were normal. GYN consult dated August 14, revealed no signs of forced sexual intercourse (see history —patient denied having intercourse as stated to father). Marital introitus.

(174)

Patient sustained a lower urinary tract infection and was treated with penicillin.

Her medication at time of discharge was Cogentin 1 mg. tid. and Haldol 1 mg. tid.

Diagnosis: Passive aggressive personality, aggressive type 301.81

Disposition: Discharge 11-7-72 to the parents for transfer to the Devereaux School.

HBR/em

Howard B. Rosen, M.D.

(175)

HAVERFORD STATE
BARTLEY, Kevin
8369 1

SUMMARY

This 16 year old male has been a patient since November, 1971 when he was admitted on a 403 commitment signed by his mother, as a transfer from Eastern State School and Hospital. He had been at Eastern State School and Hospital since January 11, 1968 with a diagnosis of organic brain syndrome with Epilepsy and Explosive Personality Disorder. He was transferred to the open unit of the adolescent service and came under this examiners supervision in January, 1972. He has continued to be hyper-sensitive to rejection from family and staff and often acts aggressively when depressed. Since the loss of his father, this patient has had many self doubts and low self esteem and has known to be accident prone and self destructive. With support and working with a therapeutic milieu of staff the patient has made considerable progress in recent months. He continues to require anti-convulsive medication and his seizures have been under control during his hospital stay. This patient has been known to interact with the staff and other patients in an aggressive way often asking to be hurt and punished. When self destructiveness or aggressiveness toward the staff became uncontrollable, the patient has required transfer to a closed unit for self protection or for protection of others. He generally responded well to these temporary restrictions and has not required extended use of the closed unit. At the present time the patient is living with his mother and siblings.

Since April, 1972, many referrals have been made toward finding a suitable school-vocational program in the community. Because of his being multi-handicapped with an organic seizure disorder and his emotional lability in the past, he had not been accepted. Efforts to work with his mother to allow her to become more receptive to his return to his home and community have been difficult, but have also improved considerably in recent months.

The patient was evaluated 11-20-72 by Elwyn for consideration for their school work program and it appears he may start there in the near future. Since 11-22-72, he has been on short term leave. Delays in finding transportation to our Special Education Program at Haverford State Hospital finally are being worked out.

Diagnostically, he remains 1) Organic Brain Syndrome with Epilepsy and 2) Personality Trait Disturbance, explosive type with depressive features. Tests have indicated his ability to work in a school vocational program and it is anticipated he will be discharged to Base Service Unit for follow-up care and controlled by chemotherapy once he has begun this program.

(176) Patient was placed on the following medications: Phenobarbital gr. 1 tid, Dilantin 100 mgs. tid and Valium 5 mgs. qid and Benadryl 150 mgs. hs plus 1 green placebo.

Patient has been scheduled for group therapy twice per week during his hospital stay. In all patient was in group therapy 42 times. Since January, 1972, he has been seen individually by Dr. Hammer in an approximate once per week basis. Actual attended sessions number 16 times.

1s Carl Hammer, M.D.

Philadelphia, Pennsylvania

May 10, 1973

HEARING

Before:

Honorable John Gibbons, J., Circuit Court Judge.

Honorable Thomas A. Masterson, J., District Court Judge.

Honorable Raymond J. Broderick, J., District Court Judge.

Appearances:

David Ferleger, Esq., Stanley Abramson, Esq., Ronald Soskin, Esq., 121 South 18th Street, Philadelphia, Pennsylvania 19103, Attorneys for Plaintiffs.

Barry A. Roth, Esq., Assistant Attorney General, Department of Justice, Room 323, Health & Welfare Building, Harrisburg, Pennsylvania 17120, Attorney for Defendants.

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(3) JUDGE GIBBONS: May we have the appearances?

MR. FERLEGER: My name is David Ferleger, attorney for the plaintiffs Your Honor.

MR. ROTH: My name is Barry Roth, attorney for the defendants.

JUDGE MASTERSON: Are you a Deputy Attorney General?

MR. ROTH: Assistant Attorney General.

JUDGE MASTERSON: You are an Assistant Attorney General?

MR. ROTH: Yes, Your Honor.

MR. FERLEGER: Your Honor, this is Stanley Abramson, who is going to be a graduate from Rutgers Law School and this is Ronald Soskin, who will be a graduate from Pennsylvania Law School.

JUDGE MASTERSON: We have reviewed the papers in this case. Let me ask this general question: Does the promulgation of the regulations effective May 1st with respect to children 13 to 15 cure the problem as far as the plaintiffs are concerned as to that group of children?

MR. FERLEGER: No, Your Honor.

JUDGE MASTERSON: Why not?

(4) MR. FERLEGER: The reason being that the —on two grounds. From a due process point of view the regulations allow children to be brought into an institution and deprived of their liberties solely by reason of examinations of doctors. That is in a non-emergency situation.

JUDGE MASTERSON: That can be done in the Mental Health Act as to adults on the certification of two doctors. You or I, or anybody else can be dumped in for ten days or something like that.

MR. FERLEGER: In 1971 in the Dixon case, a three Judge court in the Western District ruled that section of the Mental Health Act unconstitutional. It can't be done any more.

JUDGE MASTERSON: What do they do now?

MR. FERLEGER: Right now the only way an adult can be brought into a hospital against his will, aside from the emergency situation, is by Court commitment.

JUDGE MASTERSON: What happens in the emergency situation?

MR. FERLEGER: In the emergency situation when somebody is dangerous to himself or to other people, in that situation the County Mental Health (5) Administrator can authorize commitment for the purposes of observation and protection.

JUDGE MASTERSON: It just can't be on the certification of the two doctors?

MR. FERLEGER: No.

JUDGE GIBBONS: But it can be on the certification of the County Mental Health Administrator?

MR. FERLEGER: In an emergency situation.

JUDGE GIBBONS: How does that add to the due process? Suppose the same thing were applicable to children?

MR. FERLEGER: If the situation was dangerousness, in that emergency situation I don't have any problem with children being brought in under that emergency section which is Section 405 of the Mental Health Act.

In the non-emergency situation it is improper now to deprive adults of their liberty without a hearing, and I think also it would be improper to deprive the children.

JUDGE GIBBONS: I am afraid that is a little bit simplistic. A child say of 6 years old who is taken to a pedi-

atric ward with an emergency (6) is deprived of his liberty, and yet if you ask the child did he want to go to the hospital, in 99 cases out of 100 he would object.

It seems to me we can't look at it quite as simplistically, the due process point. It is more involved.

MR. FERLEGER: Well, at first Your Honor I was responding to the Judge's question about children 13 and older under the regulations.

In response to your comment I think it is a little bit different when it is deprivation of liberty, which means institutionalization in an institution for mental health treatment. There are a number of cases which I have cited, one being Heryford v Parker which involved a 9 year old.

In that case the Court held that when this 9 year old feeble-minded child was to be committed to live at an institution for a period of time, not to have a broken arm fixed, but to live in an institution, that a Guardian Ad Litem had to be appointed.

JUDGE GIBBONS: It may be that a guardian procedure at some point would be appropriate and even necessary, but my difficulty with approaching (7) this solely from a due process standpoint is that a suicidal child is just as much in need of emergency medical attention as is a child with a broken arm. If you surround the treatment of potentially self-destructive mental illness with so many due process safeguards you may, particularly with respect to lower income people, build in a tendency not to resort to treatment. There seems to me to be a good deal more involved here than the due process problem.

MR. FERLEGER: I agree completely with what you said for the suicidal child who acts out in a way that is self-destructive. That situation, I think, clearly is the kind of thing that presently can be dealt with through the emergency procedure. There is no problem at all, I don't think, in any county in Pennsylvania with a parent bringing in a child who is going to kill himself. The problem is, for example at Haverford State Hospital, the majority of children are brought there not for the kind of behaviors which are delinquent, stealing and running away from home. For that kind of thing there is no emergency.

JUDGE GIBBONS: You may be able to (8) establish that. We can't accept that as the fact.

MR. FERLEGER: I understand that.

JUDGE GIBBONS: But no matter whether even if that is true the process of getting the child to the hospital, keeping in mind that presumptively until 18 the parent has a firm obligation to do so, can't be made so difficult that we would be defeating the purpose of the hospitals.

JUDGE MASTERSON: It seems to me that the problem is having a procedure for someone independent of the parent and the child to review the facts concerning the child's institutionalization. I don't think that that review should occur before the institutionalization, because I agree with Judge Gibbons that that may have a deterrent effect on people having their children institutionalized when they need to be. And it seems to me that due process, meaningful due process, is served if the procedure is available so that the unwilling child can have an independent person review the facts with respect to his institutionalization, and that's why my own preliminary is that the

May 1st regulations pretty much take the steam out of your case as to the 13 to 18 year olds.

(9) MR. FERLEGER: There have been very few cases. due process cases involving the mental health of minors. There have been a large number of cases which are cited throughout the papers submitted involving due process for adults. Those cases make it clear that for adults, adults can't be deprived of their liberty without all kinds of procedural protections. The Wisconsin three Judge court in Lessard v Schmidt just narrowed down commitment to adults to dangerousness in any case. Cases involving the commitment of juveniles have mainly been of the Gault type, cases which involve committing the juvenile to rehabilitate or treat the child to help cure behavior or in some cases to cure mental problems. When those cases have examined the situation they have said that the fact that parents or somebody else wants the kid in an institution, even for his own benefit, doesn't mean that due process doesn't have to be provided.

JUDGE MASTERSON: I think that there is a point at which the natural right of parents and the extremes of due process collide. I suppose technically you could argue, with just as much force, that I ought not to be able to spank a child, maybe I (10) shouldn't, until I go before a Magistrate and convict the child of errant behavior.

Now I think you can put these things under much too fine a microscope, and I am concerned about what I consider to be meaningful deprivations. I don't think it is terribly meaningful, it doesn't upset me much, that a parent can commit a child to a mental institution and the child may be there for three or four days against its will before an independent person reviews the circumstances

of their commitment. It really doesn't bother me that much that there may be that amount of deprivation because I think that the arguments for giving the parents the right to make the initial decision are, for me, very persuasive. I don't know how my brethren feel about that.

JUDGE GIBBONS: Another thing that disturbs me about this, about your case, it presumes that the hospital is in an adverse relationship to the child, or at least it presumes in the relief it requests that the hospital should be put in an adversary relationship with the child.

Now in the Gault situation that is clearly the case, although the original theory was otherwise, (11) it has quite clearly become the case that the child is being incarcerated for criminal behavior, and that the societal control is adversary. I don't think we can make the same assumption about the hospital.

You see we are dealing with infants, the parents have a parental responsibility. The State, at least during minority, also has a parent patriary responsibility, which it may be discharging through the hospital, and when you say a due process requirement you are assuming that the hospital can not accord due process; that it can not discharge the State's nonadversary responsibility.

After all, the hospital is, if anything, a potential adversary of the parent rather than the child.

MR. FERLEGER: Your Honor, the parents patriae concept is involved, and there is more than one case which says that in the case of admitting juveniles, parents patriae means that you have to provide due process which included in that case court type process.

In terms of the hospital being an adversary, I don't feel that the hospital is an adversary. (12) I feel that the hospital is sincere in its attempt to treat the children. However, the concept of physicians, of doctors, deciding whether deprivation of liberty is appropriate is the very thing that was rejected in the Dixon case as is the very thing that has been rejected—

JUDGE GIBBONS: That is a different situation.

JUDGE MASTERSON: In any event, I would agree that you can't give the doctors unreviewable authority, but it seems to me that it is cured once you establish a procedure where the doctor's decision is independently reviewed by someone who has responsibility to no one other than the child.

I think one of the things we would all like to know, what are the facts here?

JUDGE BRODERICK: May I ask a question along those lines?

JUDGE MASTERSON: Yes.

JUDGE BRODERICK: Mr. Ferleger, I have been concerned about your second statement here this morning, and that was in response to, I think, Judge Masterson's question to you as to whether or not these regulations that were recently enacted (13) didn't take care of the situation. And you said you were primarily, or words to that effect, concerned with what, I will use the term I don't think you did, the delinquent child. Not the child that needs emergency treatment for mental or an emotional disorder, but the delinquent child. And I have a problem trying to figure out how that delinquent child would get

into the State mental hospital such as Haverford. Can you answer that for me?

MR. FERLEGER: I will be glad to Your Honor.

JUDGE BRODERICK: How do they get in there?

MR. FERLEGER: First let me preface that by giving the factual basis which isn't before the Court, but it will take a sentence to mention it.

There is a study that is being done at Haverford by the Research Department, a computerized study of hundreds of adolescents admitted during a four year period, and they have computed the types of behaviors that bring kids into the hospital. I have just glanced at it briefly, and 20 or 30 per cent, I am not sure of the exact numbers, came in because of stealing.

(14) Now the reason is, to answer your question specifically, that kids do a lot of things that to juvenile court judges, and to the delinquency laws, look like delinquent type things, and to a psychiatrist are psychiatric symptoms of a mental problem. And for those kinds of things the parents very often have the alternative. They can go through the juvenile court process, or they can go through the hospital.

JUDGE BRODERICK: That's the one question I wanted to ask you.

JUDGE MASTERSON: Let me ask this.

JUDGE BRODERICK: Yes.

JUDGE MASTERSON: Do you want to deprive the parents of going the hospital route rather than the Juvenile Court?

MR. FERLEGER: No. I have no problem with the parents going the hospital route, but I think that just as in a juvenile court process the Judge makes the determination about whether or not the child is delinquent, so the mental health process Judge should decide whether or not the person is mentally ill.

JUDGE MASTERSON: So the Judges will have (15) to be reviewing all of these commitments of adolescents to State mental institutions?

MR. FERLEGER: Judges review all involuntary commitments of adults and I feel it would be proper to also review the commitments of juveniles.

JUDGE MASTERSON: I don't think they review all the involuntary commitments of adults unless a petition is filed.

MR. FERLEGER: But if there isn't a petition filed there can't be an involuntary commitment at all.

JUDGE BRODERICK: Do you know whether someone can get into the Haverford State Hospital as a delinquent without being sent there by the Court Mr. Roth?

MR. ROTH: Your Honor, I am not apprised of that. I would assume that the person would have to be sent there by the Court.

JUDGE BRODERICK: I have always been under that impression and I didn't know, and I am not saying that it is a good idea if a parent wants to avoid the juvenile legal machinery, but I had always been under the impression that a parent couldn't voluntarily go out and say, "Look, I have a bad boy (16) here and I want you to take him in." I didn't think it worked that way.

MR. FERLEGER: Your Honor, an affidavit that we filed with the Court involves a boy who was on probation from Juvenile Court for truancy before he came to the hospital, and in his affidavit he explains that the doctor at the hospital wanted him to go to reform school, and it was made clear to him that he had a choice; to be deprived of his liberty in the mental hospital, or in reform school. And the behaviors are identical. It is just that a doctor puts a psychiatric diagnosis—

JUDGE BRODERICK: That is his affidavit.

JUDGE GIBBONS: Let's assume we take that as true, and take that there are such cases. Your position is that in no case should the juvenile be committed without a judicial proceeding. Let's assume that he—

JUDGE BRODERICK: He has an exception on that.

JUDGE GIBBONS: Except in the emergency, but that would be a short term commitment.

MR. FERLEGER: Your Honor, or in the voluntary situation. There are—

(17) JUDGE GIBBONS: Now let's take the voluntary situation by way of contrast.

How competent is a juvenile of 13 to make a decision to commit himself voluntarily? That is first.

Second, if we are talking about a judicial proceeding, do we have grounds, at least so far, for laying down a rule that the Guardian Ad Litem in that proceeding may not be the parent, which in effect, it seems to me that is going to have to be your position, that in every instance you are going to convert the commitment proceeding into an adver-

sarial proceeding between a Guardian Ad Litem, because the juvenile can't appear otherwise, and the parent.

MR. FERLEGER: Heryford v. Parker involved a situation where the 9 year old, according to the Court, was entitled to a Guardian Ad Litem other than the parent. In terms of the voluntariness of a 13 year old in that capability, there are situations at Haverford Hospital, as a deposition that has just been transcribed will indicate to you, where children are in the hospital and where the hospital thinks they should remain but the parent (18) who signed them in now decides to take them out, and under the law now, the situation where a hospital thinks a child should be there and the parent wants the child out, in that situation the parent can, and does, take the child out.

JUDGE GIBBONS: The State has a remedy. There are other statutes governing that situation. They can terminate parental rights. There are other steps that can be taken.

MR. FERLEGER: Or they can have the regular Section 406 civil commitment.

JUDGE GIBBONS: I am not concerned with that case because assuming that the hospital is acting for the child there are ample—

MR. FERLEGER: But there are other cases Your Honor, like one which I know where the child wants help, the child would love to sign into the hospital because the child is afraid of killing herself in this case, but the parents don't want to sign the papers. And in that situation you are telling the child that you have to run around to welfare agencies, or to the State authorities in order to get in.

JUDGE MASTERSON: How would we handle (19) that?

MR. FERLEGER: The way it can be handled Your Honor is by permitting any person to apply for voluntary care in the hospital.

JUDGE MASTERSON: Regardless of age?

MR. FERLEGER: Right. The hospital would then make their evaluation of the need, and if there was a need for commitment then a person could stay, even if the parent decided that the child didn't need help.

You see, there is—

JUDGE GIBBONS: Of course you are going far afield. You can't contend that the inability of a juvenile to commit himself voluntarily is a due process violation.

MR. FERLEGER: That is an equal protection issue.

JUDGE MASTERSON: Or equal protection. Because follow that where it leads. It leads to us conferring by judicial decree all of the rights on children, maybe you draw the line at 7, maybe you wouldn't, that are now conferred on them by law at age 21, 18 in other states.

MR. FERLEGER: No. I think it is different (20) when it involves institutionalization, when it involves treatment for mental health problems.

JUDGE MASTERSON: Children can not be treated differently than adults, the theory is, in this setting. Then that means if it is true in this setting, it ought to be true in any other setting, and I don't think I am going to go that far. I am not prepared, by judicial decree, to say that 12 year olds are as mature as 18 or 21 year olds.

JUDGE GIBBONS: For example, would you go so far as to say that a 12 year old should be free to consent to an amputation?

MR. FERLEGER: I have been doing some research in the past couple of weeks on sterilization in juveniles in Pennsylvania, about which there is very little, almost no law.

In that kind of situation I would like, as I would in the hospital situation, some independent person to make that kind of decision.

In the hospital situation, if a child—

JUDGE GIBBONS: If the independent person designated, until the State takes steps under existing statutory authority, to substitute another guardian, is the patient's guardian. The parent—

(21) MR. FERLEGER: Your Honor, for the situation that Judge Masterson asked about, I am not saying that a child can come to the hospital and sit down and say, "I am staying here. You have to treat me." That is not what I am saying.

Under the law, and under what I am proposing, the hospital would have to make its own examination to determine if the child was mentally disabled.

JUDGE MASTERSON: It is a little inconsistent. You are willing, in effect, to take the hospital as the substitute guardian in the child voluntary setting, but not in the involuntary parental application setting.

JUDGE GIBBONS: If they are nonadversary in one, why are they not nonadversary in the other?

MR. FERLEGER: The reason Your Honor is that when it involves an involuntary commitment, when it involves saying to a child that you have done things and this means you are sick, and you have to stay here, that doctors in the hospital shouldn't be making that decision. When it involves a child saying, "I want to be here." Then the State doesn't have any authority—

(22) JUDGE MASTERSON: How about the situation where the child is angry at its parents and, you know, doees this to wound the parents and persuades the doctor, well, maybe the kid can use a little treatment for a week or two and now the parents can't get their own child back? That is a little frightening to me.

MR. FERLEGER: Well, it is. The thing, though, that is more frightening to me is the parents who are angry at the child and take the child to the hospital.

JUDGE MASTERSON: Right. That is why I would like to get some of the real facts. I think, by and large, most parents discharge their parental functions with respect to their children in a responsible way. I think most parents love their children and behave in that fashion. I think that this whole lawsuit is about very very few parents who either, through ignorance or their own emotional problems, abuse the parental right and attempt to have State agencies reinforce their abuse. I don't think there are very many of those cases and I wouldn't want to upset the whole parent-child relationship in this, and in other respects simply (23) because there may be a few cases where this abuse occurs.

So I think we would like to get some kind of factual record. When is that study going to be completed?

MR. FERLEGER: Well, the people who are doing the research have agreed with me that they will, even though they are not complete with the study, they will provide answers and statistics from the study even before it is completed. I will be getting an affidavit—

JUDGE MASTERSON: Let's talk about what kind of facts we want and how we could get them.

JUDGE GIBBONS: Before we go into that, let me ask this. Among the original plaintiffs, how many are still in Haverford?

MR. FERLEGER: There is one person that the State said the patient was on a short term leave. I am not sure, as of now, whether or not he is still at the hospital.

There is another plaintiff who I am near certain is still in the hospital.

JUDGE GIBBONS: Well, we can hardly act on near certainty. If there is nobody in the (24) hospital, a good part of your case is moot, particularly your contentions with respect to voluntary admission, because none of those plaintiffs are seeking voluntary admission.

Now that brings up the next question. These are all children, minors, and there is at least some indication that some of them may be actually, or potentially, unstable. It seems to me that we have to get some information about whether or not they would be adequate class representatives. We can't proceed even with a class suit without a live plaintiff.

JUDGE MASTERSON: And we have a preliminary threshold question; can someone who is not Sui Generis

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be a class plaintiff, or would we not have to appoint, or have you go to the local Court to appoint a guardian?

MR. FERLEGER: Your Honor, my understanding of the law in this regard is that the Federal Court would apply for this purpose, for competence, the State law. We have brought this action as a complainant case as the next friend of the plaintiffs.

JUDGE MASTERSON: How do you get to be the (25) next friend. It is usually the parent, and if not the parent, if you are representing the person of a minor, you have to be appointed guardian of the person.

MR. FERLEGER: For incompetence I believe Pennsylvania State Law, and I believe for minors, permits the person to choose—

JUDGE MASTERSON: The parents of someone in Loco Parentis, how do you get to be in Loco Parentis?

MR. FERLEGER: According to Pennsylvania law, a person in Loco Parentis does not have to be appointed by the Court. A person in Loco Parentis—

JUDGE GIBBONS: How do you get to be that person?

MR. FERLEGER: Well, in a number of ways: One way being that my job, my relationship with Haverford State Hospital, it happens to be the defendant, is to represent patients there, to act for patients.

JUDGE GIBBONS: First of all, if you have a connection with Haverford State Hospital in some official capacity, if I were sitting in the Orphans' (26) Court that would rule you out as a guardian.

MR. FERLEGER: Your Honor, not in that sort of official capacity. My connection with Haverford State Hospital is to provide independent legal advocacy—

JUDGE GIBBONS: All right. Let's assume that, and let's assume you would qualify as such a person. You have not, at least on the papers I have seen, we have individual plaintiffs acting thus far in their own right. It seems clear from the papers before us that as to some of those plaintiffs their case is now moot.

As to the others, their case may not be moot, but we need a good deal more guidance than we now have as to whether or not they are adequate class representatives, and also whether or not they can proceed without a guardian of their person. And if they can not, who that guardian should be, and if such a guardian is appointed can he also act as a class representative? There are potential conflicts too that would concern me that grow out of the potential difference in the problems of the 17 year old as contrasted with the 13 or the 6 year old. And query, if the same person could act for (27) all of those people.

MR. FERLEGER: In terms of the class representative adequacy I would like to make a couple of points.

First, that there have been a large number of cases, the most well-known recent one is the Wyatt v. Stickney case in Alabama; persons who are in mental hospitals, in person, you don't have to be an incompetent to be a patient, wherein patients have been class representatives. In terms of the adequacy of the factual background, I believe that the Interrogatories which we seek to have answered, one of the reasons we asked this portion of them was to find out what the class consists of in Pennsylvania.

We have asked the State to provide the names and the situations of the juveniles who are now incarcerated against their will. If the Court knew that, the Court would be in a better position to determine the adequacy of our representatives.

JUDGE MASTERSON: All right. Well, that raises a question that I guess we might as well address ourselves to, to the Commonwealth's motion—

(28) MR. FERLEGER: I didn't hear you.

JUDGE MASTERSON: The Commonwealth's resistance to answering your Interrogatories.

Are you continuing to resist answering those Interrogatories?

MR. ROTH: Yes, Your Honor. We are continuing to resist answering for all the institutions.

JUDGE MASTERSON: Why? Simply because it is such a big job?

MR. ROTH: Not only that, but there really has been no determination on our Motion to Dismiss. Notwithstanding that, and not to mislead anyone, we informed Mr. Ferleger he may go to the various institutions and obtain the information as well as we have gone ahead and received all the materials from our State schools and hospitals.

Now Mr. Ferleger has defined facilities as including day care centers and we have over 600 facilities in the State. We are going throughout the entire State having the information collected. We did furnish him with the Haverford material at the outset, and we are not going to deny furnishing him with this material, but before we

want to go on, and if we need to be corrected we will, but before (29) we went to proceed and continue this burdensome procedure, we wanted to know if our Motion to Dismiss would be granted.

JUDGE GIBBONS: I think we can assume; that without a record we are not going to grant your motion, except to this extent: I think, and frankly you don't even want this relief, I question whether the hospital is a proper party. It is not a person within the meaning of Section 1983. It may be that because of some features of Pennsylvania law it may be suable under Federal jurisdiction or you may be able to find a State remedy that would be picked up 420's C Section 1988. But on the surface it would look as if the hospital would be entitled to get out, because it is not a person. That would not end the lawsuit, of course, and I don't know how interested the State would be in gaining that small technical advantage.

But as far as the rest of the lawsuit I think you can assume that we will want to make a record before we decide whether or not to dismiss.

MR. ROTH: Your Honor, if I may, we have been talking about the proposed regulations and they were to be effective on May 1. However, we received (30) several comments about these regulations, and the main comment was, how do we provide for mentally retarded children in the sense of what opinion can be forthcoming for them. So we have amended our regulations which I am prepared to give you a copy of, and we are going to publish these in the Bulletin to take effect July 1.

In addition to what we already had in the regulations published March 24th, we have provided that after

six months a review will be taken, an evaluation of those proposals, and if necessary we will hold public hearings. We don't want to mislead anyone into thinking that by publishing these we are afraid of this lawsuit, and we are trying to resolve it that way. We are most concerned, above all, of the fact of stripping parental rights, and that is our major concern in this lawsuit.

JUDGE GIBBONS: Well, it obviously is ours, as you can see from the questions that have been asked.

At the same time I think on the surface some post admission procedure along the lines that you proposed in the regulations seems singularly appropriate. I don't know what the amended (31) regulations will provide with respect to the mentally retarded, or with respect to the under thirteens, which are not dealt with in the proposed regulation.

One possible approach would be that at each facility a standing Guardian Ad Litem, someone in the nature of a guardian, be appointed to review automatically after a certain length of time. And by suggesting that I don't even suggest that it is a good idea because we don't have enough facts.

MR. FERLEGER: Your Honor, I agree completely in terms of the facts, one, that is one reason why we pressed for the Interrogatories, because I don't have at this point, and the Court does, a list of the procedures that are used for juveniles.

JUDGE GIBBONS: Will there be any difficulty about that now that you know we are not going to, at least at this stage, grant your motion?

MR. ROTH: No, Your Honor. What we can do is go ahead with the State schools and hospitals.

With regard to day care centers and—

JUDGE MASTERSON: Well, wait. Are you (32) challenging procedures relating to the day care centers, and schools, or is this confined to mental hospitals?

MR. FERLEGER: I am not asking for procedures in terms of day care centers. I think Mr. Roth is misreading the State law definition for facilities. What we are asking for is for information about commitments to institutions which deal with mentally disabled people.

JUDGE GIBBONS: Well now, can you at least limit it to residential institutions?

MR. FERLEGER: Certainly.

JUDGE GIBBONS: There are mental health facilities that are on an outpatient basis.

MR. FERLEGER: Certainly.

JUDGE MASTERSON: All right. Now what does that mean in terms of the size of the job? How many residential mental institutions do we have in this State?

MR. ROTH: That would be impossible for me to answer. I can find out. One thing you have to realize—

MR. FERLEGER: I think that Mr. Roth's partial answer to Interrogatories gave us a complete (33) list of inpatient facilities.

MR. ROTH: You are talking about residential units.

JUDGE MASTERSON: We are limiting this to residential. That is what I want to know. How many inpatient residential mental hospitals do we have in the Commonwealth?

JUDGE BRODERICK: It can't be any more than 25.

MR. FERLEGER: It is certainly less than what we have here. Some of the inpatient facilities are regular hospitals with 5 to 10 beds. So some of them are only emergency. We are not talking about them.

JUDGE MASTERSON: Why don't you and your opponent here sit down and work out a schedule for the production of the information you need that is relevant to this case?

MR. FERLEGER: Certainly.

JUDGE MASTERSON: And you can be advised that the Court will require you to answer the information with respect to inpatient residential mental institutions only at this stage. Okay?

MR. FERLEGER: Certainly.

(34) JUDGE MASTERSON: Well, that seems to be the first step. Then the next step is that we would like to be briefed on the legal questions we have raised. The capacity of any of these minors to bring this action; the capacity of them to be "class representatives", the question of whether a Guardian Ad Litem should be appointed and who appoints them. And what else?

JUDGE GIBBONS: And how the class should be defined and whether or not subclasses, based on age or condition, or other considerations possibly even based on sex of the juvenile might be appropriate. I think they should certainly be brought before us on a motion to determine the class.

JUDGE MASTERSON: Yes. Right.

JUDGE GIBBONS: And with appropriate papers and with testimony, if necessary, if there are contested facts.

JUDGE BRODERICK: I am concerned about the Interrogatories, the answers. I am not so sure that I know how broad the question was, but I would certainly want to know what the present procedures are for the admission of children into those inpatient institutions, not just the inhouse (35) procedures as to how they get out, but I also want to know how they get in.

MR. FERLEGER: Those are covered by our questions 7 and 8. They are not answered.

JUDGE BRODERICK: They are covered in the Interrogatories?

MR. FERLEGER: Yes, Your Honor.

JUDGE BRODERICK: All right.

JUDGE MASTERSON: Do you need any more guidance from us right now?

MR. FERLEGER: I am not quite clear Mr. Roth has agreed to answer questions 7 and 8 involving the procedures.

JUDGE MASTERSON: He has been directed to answer them with respect to all inpatient residential mental institutions. Now if he has to be hit over the head with a brick that can be done too.

MR. ROTH: I am certain that is not necessary. I have just one question.

In bringing out the evaluation of these people perhaps it would also be worthwhile to know whether or not

the juvenile, when admitted to the institution, number one, had the capacity to even exercise the judgment to reject institutionalization. (36) I think that is a very severe question.

JUDGE MASTERSON: It is a very serious question.

JUDGE GIBBONS: That is one of the reasons why we have to get into subclasses.

MR. FERLEGER: Your Honor, I want to make one final point to your comments before, Judge Masterson.

Involving the general procedure in Pennsylvania which covers adults, which is, in fact now a situation in which the Courts do review every situation where an adult is put into a hospital against his will—

JUDGE MASTERSON: I find that really hard to believe.

MR. FERLEGER: I know. That is why I wanted to explain. Maybe I can get you some information of the number of commitments involved because I am not really clear whether it would really be any burden on the Master, the Judge who holds the hearing to hold two or three more hearings a week for three 17 year old kids.

JUDGE MASTERSON: We will get into the statistics. You will develop it here.

(37) MR. FERLEGER: That is correct, Your Honor.

JUDGE MASTERSON: All right. Now the question is scheduling. How long will it take to get the factual information together?

MR. ROTH: I would assume that is going to take a good deal of time.

JUDGE MASTERSON: Such as what?

MR. ROTH: I would like to request 90 days.

MR. FERLEGER: Your Honor, they have had the Interrogatories since 1972, since the end of December, 1972. In their memorandum they told the Court that we are working on getting the information together. I think if they have been working on it for 4 or 5 months—

JUDGE GIBBONS: Well, as a practical matter 45 days would get into the summer in any event. How about August 1st so that he can come back to the Court with any necessary discovery motions, and I certainly hope there won't be any during the month of August.

JUDGE MASTERSON: All right.

MR. ROTH: I will try my very best. As (38) you can understand the State procedure and going through your regional deputies and superintendents, including all inpatient residential centers, it is vast, and not only doing that but going back over those who already submitted information and requesting whether or not the juvenile rejected his admission and also whether or not he was capable of understanding his—

JUDGE MASTERSON: Well, it is going to be a big job for some people. It seems to me that all we are going to need is the statistical readout; how many of them objected, how many, in the opinion of the institution, had the capacity to object rationally, and et cetera.

MR. FERLEGER: Your Honor, what you have asked for, and the Court needs in terms of Judge Broderick's procedures, is the precipitated behaviors, the kind of things these juveniles were doing that brought him here.

JUDGE GIBBONS: That is a confidentiality problem there. If you are looking for that information for statistical purposes only, I assume you would have no objection to maintaining the confidentiality of identity.

(39) MR. FERLEGER: Of course not.

Could I ask the Court, since Mr. Roth has said he already has some information, especially on the policies questions that Judge Broderick asked about, could Mr. Roth give us, in the near future, the information he has now?

JUDGE MASTERSON: He should give you now whatever he has and keep feeding to them whenever you get it so there isn't any unnecessary delay.

Now that also gives you the same amount of time to supply us with the briefs we requested on the legal questions. So you have a big job ahead of you, both of you.

MR. FERLEGER: Your Honor, if the information is to be provided by August 1st, I would suggest about two weeks after that, if there is no more discovery, for the briefs which would discuss the case.

JUDGE GIBBONS: That is fine.

JUDGE BRODERICK: Fine.

JUDGE MASTERSON: Is August 15th a weekday?

JUDGE GIBBONS: August 15th is a Wednesday.

Now I think I would just like to add a (40) word on this discovery program about my own attitude on this.

We can only act in the context of a lawsuit, but in fact what we are being asked to do is to examine legislation and possibly to legislate. And I think that both of you should enter into some sort of a cooperative effort to get us the kind of information that you would give to a legislative committee studying this problem. We really need help. I frankly say I am very troubled by this case and I would not want, considering the nature of the problem, to see it go forward with a lot of Mickey Mouse on discovery.

MR. ROTH: We are at a loss too in the sense that we don't know what else could be done other than giving the plaintiffs the relief they seek by providing hearings prior to commitment of juveniles, and we can't do that. We wouldn't want to strip parental power that way, and we have tried to implement additional safeguards which we feel to be acceptable. I am willing to discuss with Mr. Ferleger any other recommendations he would like to include in the amended proposals and perhaps we could solve the case that way, but my understanding (41) at this point is that nothing short of the relief he seeks will be acceptable to him.

JUDGE GIBBONS: Well, at that point if you can agree on 70 per cent of the problem, and you have to come back to us and take testimony on the balance, we will hear what the experts have to say.

JUDGE MASTERSON: Yes.

Incidentally, on that subject we expect, on the testimonial phase of the case, to have real experts advise us, because it is a very very delicate, sensitive problem. All right.

MR. ROTH: Yes, sir.

MR. FERLEGER: Certainly.

JUDGE GIBBONS: All right. They are scheduled to file their papers August 15th. We will determine a hearing date after we get your papers, hopefully in September.

MR. FERLEGER: Thank you.

MR. ROTH: Thank you, Your Honor.

MR. O'SHEA: All rise.

(Whereupon the Court recessed.)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted]

INCARCERATED JUVENILES—WHY? THE MENTAL INSTITUTIONALIZATION OF JUVENILES IN PENNSYLVANIA

An Analysis of Data Submitted by Defendants in Response to Interrogatories by Plaintiffs

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I. INTRODUCTORY COMMENT

This is a review and content analysis of facts of record in this case regarding the reasons juveniles are institutionalized in mental facilities in Pennsylvania. The indented and other quotations, unless otherwise indicated, are the reasons given by the *institution and doctors themselves* for the confinement of the juvenile.

II. EXTENT OF INFORMATION

On September 15, 1973, Plaintiffs filed an analysis similar to the one below based upon information regarding

state institutions for the retarded. Since that time, the Defendants have provided information regarding juveniles in the twenty state mental hospitals and this new data has been incorporated into this study.

While—as the tables below indicate—the Defendants have failed to provide all the information this Court required, enough is presented to provide a substantial factual basis for the proceedings in this matter.

The raw material analysed below is in the record of the Court and includes a survey of all mental facilities in Pennsylvania operated or licensed by the Defendant Department of Public Welfare. Data was collected on the admissions of juveniles, the reasons for such admission and the relationship between the applicants and the juveniles.

III. WHAT IS SHOWN—IN GENERAL

The record depicts numerous private tragedies and gross personal and medical difficulties in which it is appropriate for the juvenile to be maintained in an inpatient residential setting.

However, as detailed below, there are many cases in which it is shocking that institutionalization was resorted to or in which it was done not to benefit the child but to benefit the parent or parents. There is little support here for a blanket presumption of proper medical or parental action.

Many of the children in institutions are there because of difficulties adjusting to the norms of our society. The psychological term often applied is "Adjustment reaction of infancy and childhood"; this is attributed to the greater

fluidity of all behavior at this age and characterized by such symptoms as overactivity, inattentiveness, shyness, feeling of rejection, over-aggessiveness, timidity and delinquency.[1] Difficulty in school, problems with peers, drug usage, hostility, aggression, and temper tantrums are frequent reasons given for institutionalization of juveniles. The factual allegations supporting such descriptive conclusions are often in dispute and there is at present no procedure by which such disputes may be resolved so that institutionalization may be compelled on a fair basis.

Many children are committed to mental institutions for "delinquent" non-"insane" behavior, or because parents don't care, or simply because someone didn't know what else to do with them. The following reason given for commitment of a 17 year old male to Holidaysburg State Hospital is a sad comment on this situation:

> Mr. ———— was admitted to the Cresson State School and Hospital in July, 1965. In February 1971, he was admitted to the Western State School for an evaluation. He was found to have an I.Q. too high for residency in a state institution for the retarded. Despite the absence of psychotic symptomology, he was ordered admitted due to a long history of emotional deprivation and institutionalization during a critical developmental period of his life.

Six juveniles at Western State School and Hospital were committed under sections of the 1951 mental health law and nobody has bothered, in the seven years since the 1966 law was passed, to have proper commitments instituted. A more inexcusable fact is that Pennhurst

[1] Diagnostic and Statistical Manual of Mental Disorders (DSM II), American Psychiatric Association ( ).

State School and Hospital admits that four patients (Nos. 146 to 149) have "no commitment", in other words, the state has been holding these people with *no legal authority whatsoever.*

Although incomplete information often lists MR (mental retardation) as the reason for commitment for many persons, when one looks at the complete replies of Pennhurst (where all patients are retarded), one sees the actual behaviors which provoked institutionalization (*e.g.*, runaway, incorrigible, abusive, assaultive, self-destructive, impulsive).

In a large proportion of cases, it is not even the parent who initiates the commitment. A social welfare agency, a juvenile court, a relative or others, place dozens of juveniles in institutions "voluntarily".

It is clear that some screening process is necessary. There are some persons whose commitment is or may be justified under the law and some who ought not be committed. Neither the parents, the hospitals nor the welfare agencies are presently protective of the rights of these juveniles. The question before this Court is whether the "applicants" under Sections 402 and 403 plus the medical staffs are sufficient "screens" or whether the impartial court must step in.

The examples below indicate the miserable failure of the present state of affairs, the state of affairs which the Defendants herein ask this Court to allow to continue.

IV. BEHAVIOR SIMILAR TO DELINQUENT BEHAVIOR

Many parents and agencies have institutionalized children for behavior which, if brought to the juvenile court's

attention, would have required the due process protections of the Constitution; by using the mental health process, the parents were able to avoid a hearing:

> Runaway, incorrigible (Pennhurst, No. 402).
>
> Violent episodes (Polk, No. 13, 173).
>
> Hostile, attacked children, attempted to set home on fire (Polk No. 13,077)
>
> Robbed gas station (Mental Health Center of Carbon, Monroe, Pike Counties, No. M-0-0543).
>
> Stole truck, car (Mental Health Center of Carbon, Monroe, Pike Counties, No. M-0-1210).
>
> Member of gang which participated in Robbery (Thomas Jefferson University Hospital No. 360233).
>
> Stealing (Northwestern Mental Health Center, No. 628).
>
> Involved in an altercation with a 10 year old girl whom he chased and struck (Allentown State Hospital No. 25380).
>
> Fire setting (Northwestern Mental Health Center, Inc. No. 620).
>
> Delinquent Behavior (Northwestern Mental Health Center, Inc. No. 637).
>
> Fire setting (Northwestern Mental Health Center, Inc. No. 61).
>
> Runaway (Northwestern Mental Health Center, Inc. No. 188).
>
> Arson (Fairmount Farm, No. 16380).
>
> Runaway (Fairmount Farm, No. 16187).
>
> Firesetting, stealing (Western, No. 281).
>
> Runaway, truancy, delinquent behavior (Western, No. 288).

For similar reasons, the courts commit juveniles to these *same institutions,* for example:

> Aggressive behavior towards family. Refusal to attend school.
>
> Excessive demands of attention at home. (Western, No. 285).
>
> Charged with arson and delinquency (Eastern Penna. Psychiatric Institute).

If the applicants for "voluntary" commitment had chosen to bring the above behaviors to the attention of the juvenile court, due process hearings would have been afforded the minors. In Re Gault, 387 U.S. 1 (1966); Kent v. United States, 383 U.S. 541 (1966); In Re Winship, 397 U.S. 358 (1970). The rehabilitative institutionalization of the juvenile court process requires such hearings. However, since the applicants chose to bring these juveniles to the mental hospital, rehabilitative institutionalization was accomplished without any process at all.

V. COMMITMENT FOR BENEFIT OF PARENT(S)

These instances are the most disturbing for they prove how the mental health facilities cooperate with parents and relatives in doing what Judge (now Chief Justice) Burger called

> "farming" out their kindred into mental institutions for motives not always worthy.
>
> Kent v. United States, 401 F.2d 408, 416, footnote 4 (D.C. Cir. 1968) (dissenting).

For example, one child wound up at Polk for an "interim placement while family was on vacation." No. 13,212. A mother placed her child at Western simply

because "Father out of household in the military." No. 144. One juvenile's "hyperactivity interfered with the routine of household and disturbed family members." Western, No. 15.

A newly widowed father was able to place a youngster at Western because he allegedly was "unable to care for child." No. 67. The same hospital accepted a child from a mother because of "desertion of father." No. 131.

In another striking case, a mother and father who had emotional difficulties themselves institutionalized their child at Polk because they held the "problems of the child . . . responsible for their emotional adjustment." No. 12,482.

One institution accepted a juvenile because: "Difficult to care for Loretta and her presence confines the parents in the home." Western, No. 73. A boy named Joseph left "no free time for mother." Western, No. 13. If these are proper reasons for depriving someone of liberty, then the state could summarily lock up almost every child that parents present at the hospital doors.

In numerous cases, children are the ones who are forced into treatment when it is the *family* as a whole which, according to the hospitals, has the problems. See Henry, *Pathways to Madness* (1973); Esterson and Laing, *Sanity, Madness and the Family* (1964):

> Family Problems (Philhaven Hospital, No. 5647)
>
> Family Conflicts (Institute of Penna. Hospital, No. 94-94-33)
>
> Family problems, needed separation from the family (Wernersville State Hospital)

In similar cases, it is the least powerful member of the family—the child—who is shunted off to the mental hospital when the parents decide they cannot or do not wish to deal with the situation:

> Unmanageble at home, attitude of bold indifference, resents all discipline, compulsive eating (Allentown State Hospital, No. 25741)
>
> Problems with family (Philhaven Hospital, No. 5692)
>
> Began to have trouble handling his angry and hurt feelings toward his parents. Took these feelings to school with him. (Allentown State Hospital No. 25520)
>
> Runaway, Conflict with Parents (Institute of Penna. Hospital No. 94-93-74)

VI. "WHICH CHILD DO WE COMMIT?"

Families with more than one child may use the mental hospital as a way of reducing the number of family members. For example,

> Physical burden on mother who has three additional children. (Western No. 36).
>
> He is one of three mentally retarded in the family. Coping with this problem is simply too much for the family. (Polk No. 13,103).

When a decision is being made as to which, if any, of three children is to be deprived of liberty, is this a medical decision? Will there be any protection for the child whose "number is up"?

VII. JUVENILES COMMITTED BECAUSE OF PARENT'S PROBLEMS

In a suprising number of cases, there was nothing serious reported wrong with the child but a parent's problem caused a commitment. A few outstanding examples:

> Became argumentative and wanted to stay out of school. Patient's mother overdosed and was hospitalized. Patient then had to be hospitalized. (Warren State Hospital).
>
> Neglect, Social Deprivation (Stillmeadow Home for Exceptional Children No. 1145).
>
> Neglect, Unstable home environment (Stillmeadow Home for Exceptional Children No. 1138).
>
> Mother has tuberculosis. (Western, No. 129).
>
> Emotional instability of mother. (Western, No. 127).
>
> Hospitalization of mother is apparent reason for admission. (Polk No. 11,985).
>
> No serious behavior problem; admitted due to parent's inability to provide a satisfactory home environment. (Laurelton No. 42).

A court hearing could have explored the facts in these cases, and found a less restrictive alternative which would not punish or "treat" the child for a parent's difficulty.

VIII. IMPROPER BASIS FOR INSTITUTIONALIZATION

Despite Levy v. Louisiana, 391 U.S. 68 (1968), and similar cases, these were the sole reasons Western gave

for the commitment of three persons to that institution (all signed in "voluntarily" by the mother):

> Quite active and destructive. Illegitimate. (No. 226).
>
> Sometimes hyperactive. Illegitimate. (No. 228).
>
> Illegitimate. Inadequate mother. (No. 227).

Polk readily accepted a young boy for this rather unusual reason:

> "He has no playmates, planned activities, exercise. Presently he does nothing except sit in school and in front of the TV at home," stated the parents. (No. 12,836).

Although a child could have been receiving "training for autonomy," the parents wanted only "services and sheltering" so one young woman remains at Polk without such training. No. 13,221. The only reason given for one patient is "Admitted to Polk State School and Hospital for educational purposes." No. 12,811; state law now requires public schools to provide education to all, including the retarded.

IX. INSUFFICIENT BASIS FOR INSTITUTIONALIZATION

Physical Problems Alone

Three children were committed to mental hospitals because of physical ailments. At Saint Francis' Hospital one child was committed for ulcerated colitis (No. 13-58-69); another for psychosomatic complaint (No. 11-81-06). A third child was put in the Institute of the Pennsylvania

Hospital for weight loss (No. 94-88-05). A physical ailment alone is an insufficient reason to put an individual in an institution.

School Problems Alone

There are 5 children in Saint Francis' Hospital for not going to school. This list is as follows:

School phobic (No. 12-87-29).

School phobic (No. 12-80-40).

School phobic (No. 11-17-68).

Non-school attendance (No. 14-57-10).

Non-school attendance (No. 14-18-89).

Not going to school hardly seems sufficient reason to commit a child to a mental institution.

Drugs

It is understandable that when a parent finds his child is using drugs he becomes concerned and looks for help with the problem. Under the existing laws concerning juvenile commitment it is too easy for a parent or guardian to evade their responsibilities by having the child commited. Drug usage alone is not a sufficient reason to commit a person to a mental institution unless the facts and alternatives have been considered by a court. A partial list of juveniles committed for drug related activities is as follows:

Mental Health Center of Carbon, Monroe & Pike Counties:

Overdose (No. M-0-1174)

Overdose (No. M-0-1165)

Drugs (No. Z-0-1104)

McKeesport Hospital:

Medical overdosage (No. S.K.)

Medical overdosage (No. R.M.)

Medical overdosage (No. R.W.)

Medical overdosage (No. R.K.)

Medical overdosage (No. T.G.)

Medical overdosage (S.C.)

Medical overdosage (T.S.)

Fairmount Farm:

Drugs (No. 16155)

Drugs (No. 16147)

Drugs (No. 16027)

Institute of the Penna. Hospital:

Drugs (Nos. 94-90-72, 94-95-23, 94-93-00, 94-94-92, 94-93-52, 94-91-42, 94-95-32, 94-95-57, 94-91-87)

One juvenile has even been committed for a *"fake* drug overdose." St. Francis General Hospital, No. 11-85-22).

X. ILLEGALITY OF GENERAL ADMISSIONS

Mental health facilities are required by the mental health act to receive patients *only* pursuant to the statutory provisions of the statute. However, 11 facilities for which data was provided admitted that, rather than using the proper provisions of the law, they accept mentally ill juveniles as "general admissions."

This illegal method of commitment denies to juveniles the presently scant protections of Sections 402 and 403

and also denies them the protection of the new regulations the state has adopted.

By going outside the mental health act, the patients' rights (Section 423) need not be enforced and other rights are denied, e.g. the right to be discharged when treatment is completed (Section 418), the right to leaves of absence (Section 419), the right to review by the Department (Section 420).

These are the facilities which presently act in this improper manner:

Happy Hill
Don Guanella School
St. Mary of Providence School
Ivy Mansion for Exceptional Children
The Evans School
Clifford Nursing Home
Camphill Special School Inc.
Greenwich Home for Children
Refuge Home for Children
Merry Acres
Pleasant Manor Inc.

XI. CONCLUSION

The above data show that special, personal and legal judgments enter into decisions to institutionalize juveniles; by no means is it purely medical decision. Indeed, where the medical people are involved, as in all the cases cited above, abuses still occur.

The wisdom of allowing and requiring courts to determine whether someone should be institutionalized is

brought into clearer focus by the goings-on which the present mental health system permits. As the tables below, especially Table 3 indicate, it would be no great burden on local courts to hold hearings for the small number of juveniles admitted each year. For example, the county in which Polk State School and Hospital is located would have had only 33 additional hearings last year; Whitehaven patients would have required only 87 hearings.

When facts are disputed and careful judgments must be made, especially where objections are made (even though there is presently no right to object), and where adverse interests are involved, there is no reason shown in the data above why juveniles should be denied the same due process as adults get in the mental health setting and as other juveniles get in the juvenile court context.

Respectfully submitted,

(s) David Ferleger, Jr.
David Ferleger, Esquire
Next Friend and Attorney for Plaintiffs
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March 26, 1974

TABLE 1 -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 402	403	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other family Members*	Misc.	Not Given**
Polk	341	0	0	330	39	0	1	1	1
Ebensburg	619	0	0	595	24	0	0	0	0
Pennhurst	109	1	0	93	5	1	2	0	4
Cresson	238	0	2***	209	25	0	5	1	0
Selinsgrove	225	0	0	196	7	0	3	0	20
Western	291	8	0	267	7	4	5	11##	5
Laurelton	70	4	0	58	6	0	2	1	0
Whitehaven	169	0	0	123	8	0	1	1	36
Hamburg	214	0	0	?*	?	?	?	?	?

* "Other family members" include grandparents, uncles, aunts, brothers.
** There is no explanation for the facilities' so frequently leaving blanks in their replies.
*** These two persons are transfers from other facilities; they are listed as "voluntary" but no applicant with appropriate legal section is given.
These 11 persons' applicants are listed as "Entrustment Agreement."
* No detailed information was provided by Hamburg State School and Hospital.

All entries refer to the number of cases involved.

Incarcerated Juveniles - Why?

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TABLE 1 -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 402	403	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other family Members	Misc.	Not Given
Allentown	71	9	1	10	2	0	1	0	60
Hollidaysburg	1	1	0	2	0	0	0	1	0
Harrisburg MH & R Center		1	0	1	0	0	0	0	0
Somerset	1	16	1						20
Fairview		0	0	0	0	0	0	0	0
Philadelphia	0	0	1						
Warren	0	5	0						
EPPI	17	2	0	15	4	0	0	0	0
Norristown	14	4	0	15	0	0	0	2	0
Torrance	0	3	0	2	0	0	1	0	0
Wernersville	33	0							
Haverford	10	113	0						123
Retreat	0	4	0	3	0	0	1	0	0
Harrisburg St. Hosp.	9	6	0	8	2	0	1	4	0
Mayview		1				1			

Incarcerated Juveniles - Why?

TABLE 2 -- COURT COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 406	Not Given**	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other Family Members*	Misc.	Not Given**	Incarcerated Juveniles - Why?
Polk	13	0	0	1	7	9	0	1[a.]	0	
Ebensburg	12	?	?	?	?	?	?	?	12	
Pennhurst	44	3	3[b.]	34	4	1	0	0	11	
Cresson	0	0	0	0	0	0	0	0	0	
Selinsgrove	3	0	0	2	1	0	0	0	0	
Western	6	0	6[c.]	2	3	4	0	1[d.]	1	
Laurelton	6	0	0	4	1	0	0	1[e.]	1	
Whitehaven	2	0	0	0	0	2	0	0	0	
Hamburg	20	0	0	16	2	0	2	0	0	

* "Other family members" include grandparents, uncles, aunts, brothers.
** There is no explanation for the facilities' so frequently leaving blanks in their replies.
a. The petitioner was the Superintendent of Polk.
b. These were 3 transfers under Section 416.
c. These 6 were under the 1951 law.
d. The County Mental Health Administrator.
e. "Deputy Administrator of Juveniles and Misdemeanants."

All chart entries refer to the number of cases involved.

TABLE 2a -- COURT COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 406	Not Given	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other family Members	Misc.	Not Given	Incarcerated Juveniles - Why?
Allentown	3	0	0	3	0	0	0	0	0	
Hollidaysburg	1	0	0	1	0	0	0	0	0	
Harrisburg MH & R Center	0	0	0	0	0	0	0	0	0	
Sommerset	1	0	0						1	
Farview	0	0	4	0	0	3	0	0	1	
Philadelphia	7	0	0							
Warren	22	0	0							
EPPI	1	0	0	1	0	0	0	0	0	
Norristown	13	0	0	3	0	1	0	8	0	
Torrance	3	0	0	0	0	3	0	0	0	
Wernersville	3	0	0							
Haverford	24	0	31						55	
Retreat	1	0	0	0	1	0	0	0	0	
Harrisburg St. Hosp.	10	0	0	3	4	0	0	3	0	
Mayview										
Woodville	8	0	0	0	0	7	0	0	1	

TABLE 3

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILI

Name of State School and Hospital	TYPE OF COMMITMENT 402	403	406	Not Given*
Polk	33	0	0	0
Ebensburg	?	?	?	all
Pennhurst	11	0	30	0
Cresson	?	?	?	all
Selinsgrove	?	?	?	19
Western	55	3	2	0
Laurelton	29	?	?	2
Whitehaven	87	0	2	0
Hamburg	15	0	3	0

* There is no explanation for these omissions in the data supplied by Defendants.

TABLE 3a

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILITIES

Name of State School and Hospital	TYPE OF COMMITMENT 402	403	406	Not Given
Allentown	65	23	2	
Norristown	17	11	15	
Hollidaysburg	0	2	1	
Sommerset	{28}		0	
Farview	0	0	0	0
Philadelphia	9	2	4	
Harrisburg MH & R Center	0	1	0	0
Warren	4	0	12	0
EPPI				
Torrance	0	4	2	0
Wernersville	12	0	3	0
Haverford	10	113	24	0
Retreat	3	1	1	0
Harrisburg State Hospital	7	13	14	0
Mayview				
Woodville	4	20	7	0

TABLE 4

OBJECTIONS TO TREATMENT *

Name of State School and Hospital	Objected at or after Commitment	Capacity to Object Yes	Capacity to Object No
Polk	0	--	--
Ebensburg	?**	?	?
Pennhurst	0	--	--
Cresson	?	?	?
Selinsgrove ***	15	52	3
Western	15	6	8
Laurelton	7	3	4
Whitehaven	?	?	?
Hamburg	0	0	0

* All the data here are questionable both in terms of their incomplete and the fact that the replies are frequently qualified by such terms as "objection on the record" or "don't know."

** The question marks ("?") indicate no reply by the facilities.

*** Most Selinsgrove patients, except for those tallied here, are co severely or profoundly retarded.

The capacity to object is determined solely by the facility without reported judicial determination of incompetency for that purpose.

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TABLE 4a

OBJECTIONS TO TREATMENT

Name of State School and Hospital	Objected at or after Commitment	Capacity to Object Yes	Capacity to Object No	Capacity to Object Not Given
Allentown	16	1	15	0
Hollidaysburg	0	0	0	0
Harrisburg MH & R Center	1	0	1	0
Sommerset	1	1	0	0
Farview	0	0	0	0
Philadelphia				
Warren	27	0	27	0
EPPI				
Norristown	16	4	12	0
Torrance	0	0	0	0
Wernersville	10	7	1	2
Haverford				
Retreat				
Harrisburg State Hospital	16	3	10	
Mayview				
Woodville	16	10	6	0

CERTIFICATE OF SERVICE

I certify that on the 26th day of March, 1974, I mailed true and correct copies of the foregoing to Marx Leopold, Esquire and Barry Roth, Esquire, Counsel for Defendants, at their offices at Office of Legal Counsel, Department of Public Welfare, Health and Welfare Building, Harrisburg, Pa. 17120.

William Jameson

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted]

ARGUMENT ON PLAINTIFFS' MOTION FOR A CLASS ACTION DETERMINATION AND ON DEFENDANTS' MOTION TO DISMISS

Philadelphia, Pa., April 16, 1974
(10:00 a.m.)

Before:

Hon. John J. Gibbons, C. J.

Hon. Daniel H. Huyett, 3rd, J.

Hon. Raymond J. Broderick, J.

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(2) Present:

David Ferleger, Esq., Attorney for Plaintiffs, Mental Patient Civil Liberties Project, Philadelphia, Pa. 19107.

Barry Roth, Esq., Attorney for Defendants, Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa. 17120.

JUDGE GIBBONS: May we have the appearances?

MR. FERLEGER: My name is David Ferleger, counsel for the plaintiffs.

MR. ROTH: My name is Barry Roth, counsel for defendants.

JUDGE GIBBONS: We have this morning, in addition to the defendants' motion to dismiss, several items to which I'd like to have counsel address themselves. First, is the status of the plaintiff as a class representative, represented by a next friend, rather than a guardian ad litem. In that connection, we call your attention to the fact that in Dixon versus the Attorney General of Pennsylvania, Judge Biggs, in the opinion at 315 Federal Supplement, 653—actually, that's a per curiam, but it probably was Judge Biggs, suggests that where you seek class (3) action representation, it is inappropriate to have a person under a disability act in that capacity.

Tentatively, we think there is some merit to that position and we would like to have counsel the issue, where a guardian ad litem should be appointed and if so, who.

Secondly, the only defendants joined are state employees. We raise the question, whether or not, in the circumstances of this case, it would be appropriate to designate a class action defendant to represent the parents of class members. You will recall that Sierra Club versus Morton indicates that an organization which has members who are in the affected plaintiff class, can be a class action plaintiff.

We are suggesting at least the possibility that an organization which has members of an affected defendant

class, in this instance, parents of either retarded or mentally disturbed children, might be an appropriate class action defendant, because there is at least a possibility of conflict in the position taken by the institutional representatives and the position which should be taken on behalf of parents. We will of course hear you on the class action determination itself and finally, we will hear you on the motion to dismiss. (4) Keep in mind, that on everything that is before us, we have read your extensive briefs, and we only want to hear material that will enlighten us, beyond what you have in your briefs.

I suppose the starting place would be the State's motion to dismiss. Mr. Roth?

MR. ROTH: May it please the court, Your Honors, in connection with our motion to dismiss, I must state at the outset that the Commonwealth, in order to perhaps shorten the proceedings of this matter is basing almost entire reliance upon the regulations that were effectuated in order to continue implementing sections 402 and 403 of the Mental Health and Mental Retardation Act of 1966.

In short, Your Honors, we feel that those sections which permit a parent or person in standing in locus parentis to admit or commit his or her child, are constitutional and that they are a function of parental rights.

Now, since the inception of this lawsuit, the Commonwealth has attempted in its review of the law to determine whether or not any other cases have been brought regarding the same exact issue. At that time, we had discovered none. We did discover there (5) were serious questions as to affording juveniles the opportunity and right to be heard prior to commitment to an institution. The Commonwealth in attempting not to strip parents of

parental powers, effectuated regulations which would generally permit any juvenile, upon admission, who objects or subsequent thereto, to be afforded counsel and undergo what is known as a "406 Commitment Proceeding". It is a section 406 Commitment Proceeding under the Mental Health and Mental Retardation Act which is the section which refers to involuntary commitments of adults, meaning those who are aged 18 years of age or older.

Now, in connection with the implementation of these regulations, we consulted with opposing counsel for his comments. We had these published. Subsequently, we received criticisms and comments and suggestions and we, in September of 1973, implemented these regulations.

Now, since that time and in a conference with Judge Huyett several weeks ago, a question was raised as to how effective are the regulations. And for Your Honors, I have a copy of the number of cases since September, 1973, where a juvenile objected at or subsequent to admission and the procedure that occurred. If I may at this time, I would like to hand that to (6) Your Honors.

JUDGE GIBBONS: Thank you.

MR. ROTH: Now, our understanding of these, which were prepared by the Office of Mental Health and the Office of Mental Retardation, through telephone, contacted every private licensed facility, State mental facility, state school and hospital, was to determine exactly whether or not the regulations were being applied correctly or whether or not a juvenile who objected at or subsequent to was being given, if you will, additional safeguards, as we promulgated. It appears that in every one of these cases where juveniles objected at admission or subsequent thereto, a petition—

JUDGE BRODERICK: Mr. Roth, would you mind if I interrupted, I wanted to ask a question?

MR. ROTH: Yes, Your Honor.

JUDGE BRODERICK: I just wanted to ask you, would you tell us just what the procedure is under the regulations? I have read them over, and I just wanted a quick interpretation of what that procedure is.

MR. ROTH: Your Honors, there are specific sections in the regulations which we may classify as a referral in order to show how the juvenile arrives at the institution. In other words, he's been medically (7) examined, psychiatrically examined by a base service unit or by a pediatrician or psychiatrist. We are talking about two different classes here although affected by the same regulations and we are talking of a class of mentally retarded juveniles and those who are mentally disabled.

Now, basically what occurs, after the institution receives the application of that juvenile, the institution has an independent examination also conducted.

Now, when the juvenile is admitted to the institution, if the juvenile at the time of admission or subsequent thereto, anytime, meaning subsequent thereto, objects to his being admitted, he will be afforded counsel, he will be given the right to contact his parents or the person who petitioned on behalf of him to arrange his commitment to the institution and generally undergo a 406 proceeding. What basically happens, is the director of the institution will, if he feels that the juvenile is definitely in need of continued care and cannot be released to the petitioner, will then request that a 406 petition occur, which will basically put it before a judge in order for a hearing to be

held and to determine whether or not the person does need institutionalization.

It should be noted that we utilize two days in order to seek contacting the petitioner, as well (8) as perhaps the base service unit. We arrived at this 48-hour basis, because in Lessard versus Schmidt there was some dicta indicating that a person's due process rights should not be deprived for more than 48 hours. We even question Your Honors whether or not that should apply to juveniles because in this situation again, we are talking about the paramount rights of parents versus juveniles and that is basically what the procedure allows.

We also have a notice which is read to each juvenile, advising him or her of their rights upon admission to the institution and that juvenile has to be age 13 or older. For those that are aged 13 and younger, we provide no notice. If a juvenile is incapable of understanding what is being read to him or her, that, also is noted on the notice proper.

JUDGE HUYETT: Is there anything more done than noted on the notice that the juvenile cannot understand the notice?

MR. ROTH: No, Your Honor. If he objects, and that's the question again since our conference I tried to gather this information and one of the questions that I unfortunately did not ask when the people were making these calls was whether or not (9) those objections include people who did not have the mental capacity to exercise judgment. It is my understanding, that if you're 13 years of age or older and object and even do not have the requisite capacity to make that judgment, a 406 proceeding still will be afforded you. So, this classification,

perhaps may be broken down even more, based upon whether or not a juvenile has prerequisite mental ability to exercise judgment.

Now, the Commonwealth is aware that plaintiffs have raised a few cases in connection with procedural due process rights afforded juveniles, namely Heryford versus Park and Seville—I'm sorry, the last name escapes me. Both of those cases indicate that juveniles may be afforded due process rights.

Unlike the Pennsylvania regulations, those statutes in question do not have any other mechanism for affording a hearing upon detention, if so requested by the juvenile.

Pennsylvania feels that these additional regulations would promote and safeguard procedures for juveniles being committed to its institutions.

In connection with the entire scope of juvenile's rights, we also contend that if Your Honors (10) feel that this Statute, these sections of the Mental Health and Mental Retardation Act are unconstitutional, we seriously question whether or not deprivation of any juvenile for any amount of time, whether it is a greater or lesser amount of time, as against enunciated in Lessard versus Schmidt, would require a due process hearing prior to commitment and we refer as we referred last year this time when we were discussing this case, to particular instances where a parent may want to put his child into a general hospital for an appendectomy or anything of that sort. Certainly, we think that deprivation of liberty is deprivation whether it is one minute or 10 hours.

The question becomes, in our way of thinking is: How soon after that deprivation occurs do we resolve a

balancing interest between parents and child and state among those three parties by affording a hearing if the juvenile requests it? Now, there's been some factual data with regard to the number of juveniles who are admitted to the state schools and hospitals and state mental hospitals throughout the past year, and it's been indicated in one of the memorandums of law, as I recall, by plaintiffs, that the number is minimal and as a result, would require (11) very few hearings. Now, in just tabulating an approximate number of state schools and hospitals and state mental hospitals, it is my understanding that there were approximately 600 juveniles admitted in the state schools and hospitals and state mental hospitals for the year 1972.

Now, this precludes, of course, the private licensed facilities of which there are 164.

JUDGE GIBBONS: If I understand this paper that you handed up to us, since September of 1973, there have been 22 hearings held?

MR. ROTH: I'm sorry, Your Honor, I don't know where you are arriving at 22.

JUDGE GIBBONS: In every instance, but one that's listed here, there was a section 406 hearing.

JUDGE HUYETT: One hospital alone had 17.

JUDGE BRODERICK: There is one here that has six and another has a six and another 17.

JUDGE GIBBONS: I'm sorry. It is a good deal higher number.

MR. ROTH: Yes, Your Honor.

JUDGE BRODERICK: May I ask a question? I guess it was the plaintiff that submitted the article, the rights of a child to refuse treatment, which (12) apparently was the recommendation of the task force on mental health for children and youth. What is their status in regard to the Commonwealth?

MR. ROTH: Your Honor, I was just going to arrive at the various levels of where the legislature is, where the task force is. The task force is an advisory committee and the members of that committee are appointed by the Governor.

Now, that committee makes recommendations to the Department of Public Welfare. They are merely advisory. That same advisory committee agreed to the additional procedural safeguards which we adopted, and which is prefaced in the bulletin, also.

Now, again, you know, it puts me in a very difficult situation, because you have the task force on one hand saying "we think that a prior hearing should occur prior to commitment in every instance" and then, the department is saying "well, let's make certain that we do afford at least enough procedural safeguards that would satisfy due process". And, so, we implemented regulations to effect that. The legislature and I just want to, you know, bring everything to your attention, because perhaps, you know, it might be more helpful in arriving at a decision, (13) Senate Bill 1239 of which I have copies for your Honors, the legislature is attempting to utilize the same procedures now by having parents commit their children or persons standing in locus parentis being afforded the opportunity to admit or commit their children.

However, they want to reduce the age from 18 to 14. So, in all honesty, we are a bit scattered in the direction that's occurring, in that the senate at this time in Bill 1239, would like to have the juvenile apply for and receive treatment, if he is age 14 and older.

Under age 14, he would again be admitted or committed by his parent or the person standing in locus parentis.

JUDGE GIBBONS: Bill 1239 proposes that only the juvenile if he's over 14 can make the application?

MR. ROTH: It proposes that the juvenile shall be allowed to do so.

JUDGE GIBBONS: That's not—

MR. ROTH: I see your question.

JUDGE GIBBONS: Can the parent also do so? Do they propose that the parent also do so?

MR. ROTH: They say any person or the (14) juvenile.

JUDGE GIBBONS: That really isn't involved in this case, because as I understand Mr. Ferleger's position as distinct from the amicus brief that was filed by the San Francisco organization, the Youth Law Center, he is not objecting to the inability of a juvenile to voluntarily commit himself without his parent's consent. He's objecting to the ability of the parent to have him committed.

MR. ROTH: Yes, I understand that to be the issue also, Your Honor. I merely wanted to refer this other development as what is currently before the legislature for Your Honor's knowledge in terms of whatever you come out with in your order.

JUDGE BRODERICK: May I ask one other question? Who adopts the regulations? Is it just the department head?

MR. ROTH: Basically, Your Honors, what happens—

JUDGE BRODERICK: Would that be Mrs. Wohlgemuth?

MR. ROTH: She approves it and then they're approved by the attorney general, so in effect, it would be Mrs. Wohlgemuth's recommendation to the (15) attorney general for the adoption of the regulations?

MR. ROTH: Yes.

JUDGE GIBBONS: Do they have the force of law in this state under some administrative code?

MR. ROTH: They have the force of law under the administrative code and also under the Public Welfare code and I can give you the specific situations. I'm sorry, I do not have those citations before me.

JUDGE GIBBONS: What is your reaction to our concern about a possible representative of parent interests?

MR. ROTH: If I understand you correctly, when you were raising that, are you indicating at that time that in other words, a guardian ad litem should be appointed?

JUDGE GIBBONS: No, there are two questions. The guardian ad litem goes to the adequacy of the class representative, assuming we grant class action treatment. But that would leave a guardian ad litem as a class representative of the class consisting of actually or potentially involuntarily committed minors. It would leave the defendants, the state employees, whom you represent, but it would leave the representation of the parents who obviously have an interest in this statute in your hands.

Now, obviously, (16) the attorney general has some interest in advancing their point of view, also, I suppose, but is there a potential conflict between the interests of the institution and the interest of the parents? If so, should we consider whether or not somebody, let us say, the Pennsylvania Association of Retarded Children, which undoubtedly has members in the class of parents of the plaintiff class, should not be joined as a defendant, so that we get a different point of view?

MR. ROTH: I would think, Your Honor, in regard to that, that the state institution act is in a somewhat adversary position to the parent, and I say "adversary", in the respect that if the parent wishes to admit or commit his child and follows the procedures outlined, the institution still will have the ultimate say in whether or not that child is institutionalized based upon their independent determination—psychiatric determination.

So, if anything—

JUDGE GIBBONS: But the thing is, a parents' organization might be more interested in a longer waiting period than 48 hours and might have some cogent reasons for advancing that position. They might be interested in more freedom on the part of parents (17) to involuntarily commit than the institution is.

MR. ROTH: I appreciate that, and I agree with you, they very well may. I was just trying to look at it from the standpoint, when we are talking of juvenile rights and showing that we are taking this legal presumption and we are really making it somewhat of a rebuttive presumption that the child is not as parents have alleged, railroaded into institutions, that there is somewhat of a check by the institution proper, but I agree with Your

Honor, in connection with these regulations, parents groups did not submit any comments.

Most of the comments that were submitted were done by institutions, themselves, psychiatrists and I believe there was one comment by Park, as you referred to before, but the comments of parents' groups were not solicited, other than through the Pennsylvania Bulletin when we published the proposed regulations, but that may very well be, that a parents' group might have another view with regard to this. Our feeling is, and as you indicated before, not to go through our briefs, because of course, you have had them and read them, but our feeling is that parents do maintain certain responsibilities to their children and (18) among those responsibilities are the welfare and care of their children and the treatment of their children and included within that treatment is the medical and mental treatment and we feel very strongly that parents do have corresponding duties to make sure that their child is institutionalized, if necessary.

Now, with regard to the parents, we feel that the parents are the ones who first observed their child and were very concerned.

If this regulation is struck down, the parents and especially parents of poor socio-economic backgrounds will not utilize any type of procedure to get his or her child institutionalized. That as soon as you hear and from what I have heard in institutions, as soon as you hear the word "doctor" or "lawyer", poor people tend to preclude utilizing those systems, because based on their unfamiliarity with them, they're afraid and as a result the one that's being hurt the most is the one whose best interest we are trying to serve, the child and we think

there is a balancing interest here between the parents' and child' rights, and we hope we have established a fair balance by utilizing these additional safeguards.

Now, if those safeguards were found to (19) be acceptable, but perhaps the waiting period should be extended or something of that sort, of course, you know, we would do whatever the court ordered and we could always amend other regulations to reflect that, but with regard to the entire scope and the intent, we feel it would be absolutely anathema to parents and to the institution proper to now have to go through a procedure which basically can occur subsequent to the admission, if the juvenile objects.

JUDGE BRODERICK: Mr. Roth, let me ask you this: Have you considered what were the attorney general's or the department's objection to the recommendation for a precommitment hearing on the basis that's recommended here by the Task Force? I am sure you're familiar with their recommendation. In other words, what did the Commonwealth object to as far as that recommendation is concerned? Why wasn't it adopted, for instance?

MR. ROTH: Well, the recommendation came out after the advisory committee had already approved the regulations which were implemented.

JUDGE BRODERICK: Oh.

MR. ROTH: So, they were later and also—

JUDGE BRODERICK: The reason I ask that question, it is said in this article that was (20) submitted by the defendant, that the Task Force was asked by the Advisory Committee to make recommendations regarding ap-

propriate safeguards. It may have been afterwards, but it does not indicate that in the introduction.

MR. ROTH: I will be glad to elaborate. I approached the Task Force back in January of 1973, I guess it was and indicated the proposed regulations, and I told them at the time that what we were trying to do was afford juveniles additional procedures, safeguards, and I asked them for their comments. At that time, we did not have two days, we had ten days. At that time, we had several other provisions which, for example, with regard to the mentally retarded and the mentally disabled, since I am a layman when it comes to determining the routes that a mentally retarded child or a mentally disabled child should pursue, I had put in that it would be recognized or referred from a recognized authority and referring specifically to a medical authority. What they did at that point, was distinguish and they said, mentally retarded should seek this course prior to admission to an institution.

Mentally disabled, another course. Those were the types of discussions we had, Your Honor, and then, afterwards, in March, when we published (21) the proposed regulations, we received comments.

Again, I met with the advisory committee and subsequently, we again discussed the situation, it had not been brought to my attention that they objected to them. We even placed, within the regulations here that they had been discussed with the Advisory Committee and approved.

Now, with regard to the entire concept of their change, certainly, as an instrument in the Commonwealth, I am willing to make any changes that are necessary, but

I was directed then by my superior, Secretary Wohlgemuth to implement these regulations, and they were signed off by her and the attorney general.

JUDGE BRODERICK: Prior to receiving this recommendation?

MR. ROTH: Yes, but I am not exactly sure when that recommendation was dated, but I do know, Your Honor, that with regard to the specific regulations in question, they were discussed with the Advisory Committee and the Advisory Committee, for all purposes can advise us and say do this and we may just take that as it is, advice, and not do it, but at the time we talked about the prior hearings, we talked about prior hearings as well as subsequent hearings and how we could effectuate it and make these regulations (22) stand. The committee at that time was very concerned that parents still be able to voluntarily admit or commit their children, so as a result, we continued along the path which I previously suggested, of effectuating these additional regulations.

JUDGE GIBBONS: Well—

MR. ROTH: I'd be more than happy—I'm sorry, Your Honor.

JUDGE GIBBONS: There seems to me to be four problem areas remaining. One is the 48-hour problem. One is the problem of those over 13, but lacking mental ability to exercise judgment. Another is those under 13, who apparently do not even get notice and the fourth one is those over 13. Actually, the three categories of persons and then, with respect to everybody, this 48-hour issue.

With respect to those over 13, only the 48-hour issue remains, I would think.

MR. ROTH: Yes, Your Honor.

JUDGE GIBBONS: That is, if they have mental ability to exercise judgment. What about the others, the under 13's, particularly?

MR. ROTH: The way that was arrived at, Your Honor, the doctors and the Commissioner of Mental Health and Mental Retardation advised me at (23) the time that in their opinion, especially in their medical opinion, the Commissioner is a psychiatrist in mental health, that those aged 13 or younger really were incapable of exercising any type of judgment. I don't necessarily know that that cures it, but—

JUDGE GIBBONS: Don't we need evidence on that?

MR. ROTH: Yes, Your Honor, we can—

JUDGE GIBBONS: Don't you think we would have to hold a hearing and develop some evidence on that?

MR. ROTH: I would be very pleased to have an evidentiary hearing indicating, you know, what types of juveniles are brought into the institutions.

There were several misleading statements, for example, in the two thousand pages worth of interrogatories that we answered. There was a notation that in some instances, a juvenile was institutionalized because he was a runaway. Now, one of the things which has been very difficult, and I am not saying that the state system is not misused, where juveniles who should not be admitted were admitted, I am sure that does occur. However, I don't think it is as vast as it may appear in some of the state (24) facilities and the reason I feel that is because I have

been told that personnel people at the institutions were going through the voluminous charts and it is not unlikely for a patient whose been in a hospital for a year or two years to have a file cabinet of charts, and they literally went through the charts and wrote down what they first saw as the first note with regard to the admission of the juvenile.

So, if they saw something that said "runaway" or "schizophrenic" they may not have put down the entire thing, they may have put down "runaway", things of that sort.

It is very discouraging and, of course, I am apologetic, because it should have been put in a better framework. However, we were trying to gather information to give Your Honors a feel of exactly what is occurring and the number of juveniles that were admitted and the number of those that objected and what procedures are utilized.

There is no argument in this lawsuit that juveniles are being denied a right to treatment. In fact, plaintiffs' comment that they are in fact being granted their right to treatment.

I think an evidentiary hearing would be (25) extremely helpful in connection with showing what kind of procedure occurs, what kind of backup work, if you will, goes into a psychiatrists meeting with parents, with the child and then independent of the child, to determine if the procedures utilized are sound procedures. If they are not, okay, we will change them. But if they are sound procedures and affording a minimum due process for juveniles, then we feel the regulations should remain intact. Now, I am concerned in the sense that I would

like advice from Your Honors as to if we were to hold an evidentiary hearing, exactly whom you would prefer to have representing the institutions. Shall we ferret out individual institutions, shall we have somebody renowned in the field coming in? In other words, I would like to keep the scope of it as narrow as you would like to make the proceedings move as quickly as possible, also.

JUDGE GIBBONS: We could come back to that, but I think you can gather from the thrust of the discussion that we are pretty much committed already to having the case go forward as a class action?

MR. ROTH: Yes, I realize that.

JUDGE GIBBONS: What is your position with respect to the appointment of a guardian ad litem, rather than allowing it to proceed on the basis of (26) a next friend?

MR. ROTH: Your Honor, very honestly, I was reviewing and thinking about this, and it was almost as in my initial motion to dismiss, I had claimed Haverford State Hospital could not be sued because it was not a person within the meaning of Section 1983 of the Civil Rights Act. With regard to the technicality involved, I am really at the court's pleasure. I really do not object to the going through with Mr. Ferleger as a next friend. I certainly do not want to impede the progress of the lawsuit.

By the same manner, I certainly do not assert that we are wrong, but I certainly would like to get to the merits of this lawsuit.

JUDGE GIBBONS: I take it that you have no objection to having either a co-defendant or an amicus designated to represent parents' interests?

MR. ROTH: No, I would appreciate that, Your Honor.

JUDGE GIBBONS: We will hear from Mr. Ferleger now.

MR. ROTH: Thank you, Your Honor, Your Honors, may I ask one question, please?

JUDGE GIBBONS: Yes.

MR. ROTH: With regard to the class (27) action, will that be eventually divided into subclasses, since we are talking of both mentally disabled and mentally retarded, 18-year olds as well as three-year olds?

JUDGE GIBBONS: I think we should discuss subclasses. Before we leave today, we will take that up.

JUDGE BRODERICK: May I ask another question? I just wondered, Mr. Roth, if you had discussed the effect of the decree in the Park Case, as far as this problem is concerned with the mentally retarded, since my recollection is that in the Park Case, there were commitments made by the Commonwealth to provide for a—we will say a pre-commitment hearing, a pre-change hearing and it may well be that the decree in the Park Case could have taken care of at least some of the problems.

I do not say it takes care of all of them.

MR. ROTH: I haven't looked into that as affecting the case, Your Honor, but I shall do so.

JUDGE BRODERICK: One other thing, I think there were regulations that were promulgated in connection with the decree in the Park Case and those regulations, I thought, applied specifically to the (28) retarded

children, rather than those that had some mental disturbance. All right.

MR. ROTH: Thank you.

JUDGE GIBBONS: Mr. Ferieger?

MR. FERLEGER: Good morning, Your Honors.

JUDGE GIBBONS: Don't spend time on the motion to dismiss. I think you have got our drift that this is going to have to go to an evidentiary hearing.

MR. FERLEGER: I will try to get to the point that Your Honors have raised this morning. First, I'd like to say that from the plaintiffs' point of view, this is not a parental right's case, notwithstanding for the moment that courts used these sections that are challenged and welfare agencies and social workers. The law has come a long way since children's rights were always subordinate to parent's rights. We recognize that, but nevertheless isn't it at least an arguable position that parents have some interest in this matter?

Certainly they do and in cases in our society, where parent's interests and children's interests have conflicted in the area of child abuse, child neglect and dependency laws and even in certain school cases, the courts have been very careful to make sure that the due process and other rights (29) of children were protected and that in many cases, children were given the opportunity to have counsel and guardians ad litem for the purposes of protecting their rights.

In this situation, we have here, I'd like to address first very quickly the question of the per curiam opinion in the Dixon Case that Your Honor raised with regard to

whether or not guardian ad litem should be appointed. I am pleased that Mr. Roth is willing to have me prosecute the case as next friend.

At the same time, I would like to note that according to Rule 17(C) of the Federal Rules of Procedure, the court can appoint a guardian ad litem or allow the suit to be prosecuted by a next friend.

JUDGE GIBBONS: Does not 17(C) if you can proceed as a next friend, except in a representative capacity?

MR. FERLEGER: "If an infant or incompetent person does not have a duly appointed representative, he may sue by his next friend or by a guardian ad litem".

Pennsylvania law says that children can choose their next friend. Judge Biggs in the per curiam opinion did not discuss, to my recollection, the details that we have discussed in our brief of Pennsylvania law with regard to representation. I (30) would suggest that if the court wishes to solidify the situation and be sure of th. court's position, that the court might consider transforming me from a next friend to a guardian ad litem in order for me to be under perhaps closer supervision of the court.

In another case, Judge Van Artsdalen, a case that I brought, during a hearing was faced with a situation where a minor was testifying, a minor ex-mental patient.

JUDGE GIBBONS: State defendants do not object to that procedure, and I think we would be more comfortable with it, because there is some question whether we can grant class action treatment, designating one or more of these minor plaintiffs as a class representative with a fiduciary obligation to absent class members. So,

would you prepare an appropriate order, designating yourself as guardian ad litem for one or more of the plaintiffs and, of course, submit it to Mr. Roth for approval, as to form, before you submit it to us?

MR. FERLEGER: Certainly, Your Honor. I will.

JUDGE GIBBONS: All right, now, that being behind us, let's get on to the subclass issues.

(31) MR. FERLEGER: With regard to the subclass issue, Your Honor, in considering both the mental health cases which we have cited which hold that due process adheres in mental health cases and the juvenile cases which have similar holdings for commitments to juvenile institutions, I am struck with regard to subclasses by the fact that there has never been any consideration of subclasses in those cases. With regard to adults as well as children, there are people who are committed to mental hospitals who are not competent, in a loose sense, to understand the proceedings.

I have represented some of them in commitment hearings. There are adults who do not understand the nature of the proceedings and who need counsel present in order to safeguard their rights.

There are juveniles, for example, in Heryford versus Parks, there was a nine-year old feeble-minded boy, Charles Parker who the court ruled needed a guardian ad litem to protect his interests. It seems to me from every juvenile from age one, to age 18, which is where the regulations now go, they need both counsel and a hearing and for younger and incompetent children, a guardian ad litem.

(32) JUDGE GIBBONS: Your point is that insofar as the complaint makes a due process attack on the

state regulations, all class members are in the same position?

MR. FERLEGER: That's correct, Your Honor. I, frankly, cannot see how subclasses can be workable, unless you first have hearings to determine whether or not the 12-and-a-half-year-old knows what he or she is doing or does not know what he or she is doing. I think you need counsel and a guardian ad litem in all cases, especially—

JUDGE GIBBONS: We will permit the action to go forward as a class action, designating a single class at this time, and I would have you prepare a form of order making such a designation, but providing in the order that it is without prejudice to possible designation of subclasses at a subsequent stage in the proceeding.

MR. FERLEGER: Certainly that's the way I understand the rules to provide and I will prepare that.

JUDGE GIBBONS: This is a class action under 23(B)(2), so there is no notice problem.

MR. FERLEGER: That is correct, Your Honor.

(33) JUDGE GIBBONS: Refer to that in the order, please.

MR. FERLEGER: Certainly.

JUDGE GIBBONS: Now, the description of the class will be persons under 18 years of age—

JUDGE HUYETT: 18 and under.

JUDGE GIBBONS: Yes.

MR. FERLEGER: I can read the way we defined it in the complaint. Paragraph 7, the class is defined as

all persons 18 years of age or under who have been or have been admitted or committed to state mental health facilities under the challenged provisions of the state statute.

JUDGE GIBBONS: That sounds all right.

MR. FERLEGER: I omitted the particular mention of Haverford State Hospital, since that's included.

JUDGE GIBBONS: While I think of it, we need an order dismissing Haverford State Hospital and submit such an order, please.

MR. FERLEGER: I can submit an order.

JUDGE GIBBONS: You will make an order, then?

MR. FERLEGER: Yes.

JUDGE HUYETT: Under rule 21, you can (34) do this only by court order, as I understand the rule.

MR. FERLEGER: I would like to address for a moment the question the court has raised with regard to the parents' representatives and then, I would like to talk briefly about the regulations and the plaintiffs' objections to the present regulations.

The major difficulty that I have with the need for a parent representative is that parents are not the only class which commit children under these provisions. There is a large number of children committed by social welfare agencies, by Catholic social services, by county departments of welfare, to mental hospitals. Courts, as well, use the mental health act to voluntarily commit children. I think it is probably the rural county courts that do not want to bother with the hearing, so the judge signs a child into a hospital as a person in locus parentis.

In addition, aunts and uncles and grandparents very often get involved with committing children. I see the possible interest of a group, such as P.A.R.C., in representing parents of retarded children, but I don't think they can be class representative for all the other people in locus parentis who commit children under the Act. It is my feeling that insofar as the state's (35) position has been, at least, up until today, that they are here to protect the parents' rights, as well as the institutions' rights, that I just do not see what additional facts or law the parents' organization could bring, even if they were to be considered an adequate representative.

In the mental health cases that I am familiar with and in the juvenile cases, I cannot recall any instance where parents of juveniles were called in to determine—help determine what due process meant for juveniles and in mental health cases, even in court commitment cases, there is always a petitioner, there is always somebody who wants a friend or relative committed and the courts, it is my feeling, have to determine what due process requires in a sense regardless of what the petitioner feels that it does.

JUDGE GIBBONS: But the difficulty with that, is that unlike the legislative process, where the competing interests are apt to be brought to the decision makers' attention, when you framed the lawsuit by designating a defendant, in designating a defendant, you have designated the source from which we are going to get the information and which we make what amounts to a legislative judgment.

MR. FERLEGER: I do not believe, Your (36) Honor, that a decision, with regard to what due process is re-

quired before deprivation of liberty is a legislative judgment. I believe that's a constitutional judgment.

JUDGE GIBBONS: You can call it a constitutional judgment or you can call it a decision of the lawsuit, but in fact, if we were to make a choice between a 48-hour waiting period and a 10-day waiting period, it would be a legislative judgment.

JUDGE BRODERICK: I would just like to add, Mr. Ferleger, your very argument that you have just made, that the parents and these welfare organizations and institutions have no interest and should not have an interest in this procedure is the very reason why I would want them to be represented, because, as a good advocate, you certainly are pushing for your point here, but I still feel that parents and these organizations should be represented somehow, whether it is as a party or amicus curiae in this matter, for the very reason that what you are attacking here, as I see it, you say it is not a parents' rights case, and you may be right on that statement, but it seems to me, you are saying that parents cannot waive the right to consent to the waiver of a due process hearing, which in effect is (37) what the act provides and what the regulations provide.

MR. FERLEGER: Right.

JUDGE BRODERICK: I do think we ought to get this input from that side, at least to determine whether or not such a decree which we make would infringe in any way on the rights of parents or the rights of these organizations.

MR. FERLEGER: It seems to me on the very question you feel you need that view on, that the Supreme

Court has already held in the juvenile cases that parents cannot waive their children's rights.

JUDGE GIBBONS: You may be right. That may be the way the lawsuit will come out, but nevertheless, there is at least another side to it.

MR. FERLEGER: I certainly would not stand in the way of the court getting the views of anyone that you feel is necessary. I am just not sure who it would be.

JUDGE GIBBONS: Assuming we want to proceed in that direction, do you have any suggestions?

MR. FERLEGER: Yes, in terms of—I don't know who can represent the county welfare departments, except perhaps the present defendants.

JUDGE GIBBONS: Well, the Attorney (38) General's office is here. I would think that any state agency is adequately represented.

MR. FERLEGER: With regard to the mentally retarded, it seems to me that the P.A.R.C. is the only representative I can think of.

JUDGE BRODERICK: Isn't there a similar organization to P.A.R.C. for those that are mentally disturbed?

MR. FERLEGER: Yes. I don't know if it is quite similar. There is an organization called Pennsylvania Mental Health, Incorporated, P.M.H. and Pennsylvania Mental Health has been involved both with the state in various reports and studies. They just had a commission do a study of the whole state mental health system, and I think they may have participated in lawsuits before. I am not certain, but I think the mentally ill, rather than the retarded also would need a representative.

JUDGE GIBBONS: Suppose that we were to designate such organizations as amicus, with the right to participate and examine and present testimony. We would not have to make them parties. Would either side have any objection to that procedure?

MR. FERLEGER: Not, if that's what the (39) court wishes, Your Honor.

JUDGE GIBBONS: My next question is: Can we impose the duty on counsel to approach two organizations that have been discussed or any others that occur to you, I do not want to turn this thing into an electrical anti-trust case or something, and find out their willingness to participate as amicus, keeping in mind that they will not be parties.

MR. FERLEGER: I am sure Mr. Roth and I can approach them.

JUDGE GIBBONS: You also mentioned some representative of social agencies.

MR. FERLEGER: Catholic social services I know is one that participates as well as various county welfare departments. I am not certain and maybe we can find out, whether there is some association of welfare agencies. I would guess that there is.

JUDGE GIBBONS: Certainly, we would be more comfortable having such agencies participate, at least as amicus, because what we have in mind is that you have already achieved—I don't know whether the state would have moved in this direction anyway—but you have already achieved substantial progress with regulations and asking us to go further is asking a lot. (40) We want to be sure we are on sound ground from everyone's point of view.

MR. FERLEGER: I would like to address the regulations for just a moment, Your Honor. The 48 hour provision of the regulations is not what it seems. Within the 48 hours after an objection by a child over 13 years old, the mental hospital has to contact the applicant, the parents or the agency and then begin to get a 406 Hearing, a court commitment hearing. There is no provision in the regulations that the court hearing has to be held within 48 hours, within a week, within a month or within two months?

JUDGE GIBBONS: We realize that. The regulation is saying that the hearing had to be held within 48 hours would not work, knowing the way courts operate.

MR. FERLEGER: In the Lessard Case, the court held that after someone—in order to show somebody dangerous and mentally ill, you need a probable cause hearing within 48 hours and then a full due process hearing within 10 days to 14 days.

JUDGE GIBBONS: We realize that that problem remains, that there may be the need for a two stage hearing procedure.

(41) JUDGE BRODERICK: May I ask a question, Mr. Ferleger?

MR. FERLEGER: Certainly.

JUDGE BRODERICK: With regard to the recommendations of the Task Force that you submitted, would their recommendation, if it had been adopted or if it should be adopted in the future by the Commonwealth, would that give you the protection you think is necessary?

MR. FERLEGER: Yes, Your Honor, Those recommendations, which were by the Task Force on children and

youth to the Advisory Committee, I think there might have been some confusion before, the Advisory Committee on mental health of the Welfare Department decided to reject those recommendations in making their comments to the secretary, but those recommendations, the way I read them, support the plaintiffs and would provide for a pre-commitment hearing.

JUDGE BRODERICK: I think they do and the only thought that occurs to me is that there may well be that the attorney general would be happy to discuss those, to see whether or not they might be willing to adopt them at this stage.

(42) MR. FERLEGER: I would approve of that. I think that would dispose of this lawsuit.

JUDGE BRODERICK: That is what I was hoping that you would say in answer to that.

MR. FERLEGER: The regulations, by only providing for children over 13 to have this opportunity for some due process in my mind do not protect those who need the most protection.

The child over 13, who does not know what a court looks like or does not know what a lawyer looks like or is too incompetent. The child nine years old or five years old, who gets committed, are the ones who need the most protection. They are the ones who need a guardian ad litem and counsel the most.

JUDGE GIBBONS: What is your position about the 13-year-old classification per se? Aside from the fact and I realize that you want to make for those some automatic hearing requirements, but is that a reasonable age decision on the part of the—

MR. FERLEGER: You mean if the procedures and regulations are proper, is 13 years old a reasonable cut off?

JUDGE GIBBONS: The point at which the notice is given to the child and an opportunity given (43) to ask for a hearing, rather than making it automatic?

MR. FERLEGER: To be honest, Your Honor, I am not that certain, because I do not know many children between nine and 13, and I am not sure what their usual capacities are. The oldest child I know is about six. It seems to me that as the court held in Heryford versus Park, you need the full hearing for all ages. I was re-reading Heryford briefly—

JUDGE GIBBONS: Whether or not the child asks for it?

MR. FERLEGER: That's right. In juvenile court, I am not certain whether a juvenile can come into court, and waive, without counsel or a guardian ad litem and waive the right to a hearing before commitment to a training school or reform school.

JUDGE HUYETT: What would be accomplished at a hearing with a child of let us say five years of age?

MR. FERLEGER: Counsel for the child could cross-examine the doctors who are testifying in support of the commitment, could examine the parents and other witnesses, to determine the facts. I mean all these cases to me show extreme caution by courts when fact-finding results in commitment and if a parent comes in, as happened in Pennsylvania and says, "My (44) child sits in front of the television all day and does not do anything and does not have friends and this child is mentally ill, then I think

you need a court and counsel representing the child to show the other side of the story, because there always is one.

JUDGE GIBBONS: Why, a court, necessarily? You see, this is where I tend to part company with you. There are all sorts of administrative procedures that have withstood due process and challenge and while I realize that commitment to a confined place is a very fundamental change in your status, is it necessarily required judicial action, rather than only judicial review?

MR. FERLEGER: Well, I have never seen a case, Your Honor, in which deprivation of liberty in terms of institutional commitment has ever been subject simply to the approval of administrative agencies, rather than courts. In Pennsylvania, masters hold the hearings in some counties in mental health cases, masters who are appointed by the court and make their recommendations to the court. That, to me is still a judicial proceeding and not an administrative proceeding.

JUDGE HUYETT: Masters would be lawyers?

(45) JUDGE HUYETT: There are only so many judges and recently I held a violation of probation hearing that took seven days and these hearings could be rather lengthy and there are only so many judges.

MR. FERLEGER: It could be. When Dixon was decided and the court in the middle district ruled section 404 unconstitutional, the New York Times pointed out that 14,000 patients were in Pennsylvania hospitals unconstitutionally and all those 14,000 people had to be converted to either voluntary commitments or court commitments.

JUDGE BRODERICK: You are not suggesting that because the New York Times said 14,000 that that's the

correct number, because they did not indicate that in the Dixon opinion itself as to numbers.

MR. FERLEGER: The Dixon opinion just discussed the patients at Fairview and in three paragraphs ruled section 404 unconstitutional.

JUDGE BRODERICK: I think that is all they had in front of them in that particular case, but that's neither here nor there.

MR. FERLEGER: It seems to me there wouldn't be all that many hearings required and the hearings that are required are needed and the fact that (46) more judges might be needed is irrelevant.

JUDGE GIBBONS: We can't look at it that way. There is no point in our devising a remedy that will not work. I am much more interested in devising a remedy that will work. The State of Pennsylvania could frustrate any procedure we devise by adopting an assignment of judges to other work and having these things pile up. Now, I would like to hear, when we get to final hearing what's wrong with some sort of administrative hearing, perhaps before doctors, adversary in nature, with a provision for judicial review, if necessary.

It seems to me that that would be functionally and in some respects preferable, because it would be a hearing before an agency that has a greater expertise than the typical judge.

MR. FERLEGER: Your Honor, we cite in our brief a case called Anderson versus Solomon, I believe a three-judge court case in Maryland, challenging the commitment law.

After it was brought, the statute was changed, also similar to the regulations that we have here and the court in ruling on the new law said it continued to be unconstitutional, because a mandatory (47) judicial hearing was not required, because in that case, you only received a judicial hearing if you requested one.

JUDGE GIBBONS: Not required at any stage.

MR. FERLEGER: That is right.

JUDGE GIBBONS: That's a different thing. I am not suggesting that judicial review would be eliminated, because as I understand it, habeas corpus is always available. So there is always the possibility in Pennsylvania of judicial review of whatever is done, but your due process attack is on commitment without hearing first.

MR. FERLEGER: Yes.

JUDGE GIBBONS: What I am suggesting to you is that the due process point might well be eliminated by a provision for administrative level hearing in all cases.

MR. FERLEGER: I understand your position and maybe we can brief that point further at some later point.

JUDGE GIBBONS: It seems to me that that is a more practical road to go down.

MR. FERLEGER: Your Honor, I just want to conclude by noting some of the facts in the (48) Heryford versus Park Case. The statute involved provided for hearings. The statute involved provided things almost similar to the regulations here. They provided that if a parent, for example, wanted a child committed, the parent filed a petition with the D.A. The prosecuting attorney had to file medical histories of the patient—potential patient. The

court had to have a hearing in which the medical evidence was presented even to the court and the 10th circuit struck down that statute for the reason that the child did not have counsel appointed and did not have the right to confront the evidence before a judicial officer.

JUDGE BRODERICK: I can understand that.

JUDGE GIBBONS: That can be afforded in an administrative level.

MR. FERLEGER: It could be, Your Honor. I would very much appreciate the opportunity to address that point, because it sems to be an original one, because in no mental health case that I know of, has administrative bodies been granted the right to decide when people are deprived of their liberties.

It is not final. The possibility of judicial review would always have to remain.

MR. FERLEGER: In that case, Your Honor, (49) somebody would be deprived of the judicial review through a certain period of commitment until the review can be obtained.

JUDGE GIBBONS: Exactly. Well, I think at this point you know what's bothering us and you know what we want to hear at a final hearing.

Submit an order denying the motion—the motion to dismiss and how soon can you be ready for an evidentiary hearing?

MR. FERLEGER: I think it might be best for Mr. Roth and I to discuss what sorts of stipulations we could arrive at. We talked about that a little bit with Judge Huyett in chambers.

JUDGE HUYETT: Maybe we need some type of order relating to the hearing, so we can define the issues and who the witnesses might be and what their testimony would be, so that all of it is controlled and it does not take longer than it need take.

JUDGE BRODERICK: Yes.

JUDGE HUYETT: I could prepare a proposed order and submit it to the three of us for your review.

JUDGE GIBBONS: Yes. Take up the date of the hearing and the scope of the hearing with Judge Huyett who will enter a pretrial order.

(50) MR. FERLEGER: Your Honor, as I understand it at this point, I will prepare and submit to Mr. Roth orders with regard to the class, with regard to dismissing Haverford Hospital as a defendant, with regard to a guardian ad litem and denying the motion to dismiss?

JUDGE GIBBONS: And the amicus matter.

JUDGE BRODERICK: Recommendations as to—

MR. FERLEGER: Right.

JUDGE GIBBONS: What we should do on that, after counsel approach appropriate agencies, have the agencies prepare a petition for leave to participate as amicus with an order attached.

MR. FERLEGER: Right. Thank you.

JUDGE BRODERICK: All right.

JUDGE GIBBONS: Court is adjourned.

(Whereupon, at 11:25 a.m., court was adjourned.)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley; Steve Gentile; Leslie Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Haverford State Hospital; Jack B. Kremens, Hospital Director of Haverford State Hospital; Helene Wohlgemuth, Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Defendants

ORDER

AND NOW, this 29th day of April, 1974, upon motions by the parties and argument thereon, and after consideration by this Court, it is hereby ORDERED that:

1. Haverford State Hospital be and hereby is dropped as a party defendant in this action. The com-

plaint heretofore filed shall stand amended by the elimination of Haverford State Hospital as a party defendant.

2. This action shall be maintained as a class action under Rule 23(b) (1) and (2) of the Federal Rules of Civil Procedure on behalf of the class comprised of all persons eighteen years of age or younger who have been, are or may be admitted or committed to mental health facilities in Pennsylvania pursuant to the challenged provisions of the state mental health law (i.e., 50 P.S. §§4402 and 4403). This definition of the class is without prejudice to the possibility that it may be amended or altered before the decision on the merits herein.

3. Pursuant to Rule 17(c) of the Federal Rules of Civil Procedure, David Ferleger, Esquire, Counsel for the Plaintiffs, is hereby appointed guardian ad litem for the plaintiffs and their class and he shall appear for them in this action and maintain it in their behalf.

4. The Defendants' motion to dismiss this action be and hereby is denied.

By the Court,
(s) Daniel H. Huyett
Daniel H. Huyett, 3d, *J.*

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

[Title omitted in printing.]

ANSWER

First Defense

Preliminary Statement

Plaintiffs in this Complaint attack the constitutionality of Sections 402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. 402, 403) which permits the voluntary commitment of persons 18 years of age or under by parents or persons standing in loco parentis. Defendants contend that these portions of the Act as well as regulations adopted in September, 1973, maintain the constitutionality of the attacked regulations and furthermore do not conflict with the Fourteenth Amendment to the United States Constitution.

Second Defense

Defendants admit the allegations contained in Paragraphs 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 24, 26, 29, 33, 41, 38, 39, and 40; admit in part

allegation 22 that Plaintiff Bartley who was discharged on April 1, 1973, did not wish to enter the hospital nor remain and that Plaintiff Bartley was critical of hospital procedures and deny that any hospital procedures are arbitrary or inconsistent with beneficial treatment; admit in part allegation 23 that Defendants knew Plaintiff Bartley planned to go to school and learn a useable trade upon release because Defendants made arrangements for said school and deny that "nothing worthwhile is occurring to him inside the hospital" when in fact Plaintiff Bartley was receiving specialized treatment; admit in part allegation 28 that Plaintiff Levine's parents are divorced, that her father is remarried and living in Florida, that she would like to live with her father, and deny that she was solely committed to the hospital because she does not get along with her mother and sister when in fact she has threatened their lives several times and suffers from a personality disorder; admit in part allegation 32 that Vicki Mathew's parents on November 7, 1972 applied for and received Plaintiff Mathew's discharge from the hospital, that Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations concerning Plaintiff's parents' financial means; admit in part in allegation 34 that Plaintiff Weand did not wish to become a mental patient and has informed Defendants' agents and employes of his desires to leave which occurred on December 1, 1972, that Defendants deny that Plaintiff Weand was admitted because of excess use of drugs when in fact that is part of his problem which is a psychiatric maladjustment; admit in part in allegation 35 that Plaintiff Weand has not been involved with any therapeutic drug program because his condition warrants other treatment programs in which he has participated; admit in part

in allegation 43 that a person over 18 years of age who does not wish to enter a facility may be placed there involuntariiy upon Order of the court pursuant to a petition, notice and hearing mandated by Section 406 of the Act, that Defendants deny that persons under 18 years of age who do not wish to enter a facility may be placed there when in fact adopted regulations of September, 1973 reveal that a juvenile who objects will be afforded counsel and ultimately a 406 hearing; and deny each and every other allegation contained in the Complaint.

Respectfully submitted,
BARRY A. ROTH
MARX S. LEOPOLD
Assistant Attorneys General
ISRAEL PACKEL
Attorney General
Counsel for Defendants

Dated: June 3, 1974

[Certificate of Service omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

C.A. No. 72-2272

KEVIN BARTLEY, et al., individually and on behalf of all others similarly situated, by and through their guardian ad litem, David Ferleger,

Plaintiffs

v.

HAVERFORD STATE HOSPITAL, et al.,

Defendants

FINAL PRE-HEARING ORDER

In accordance with the Court's Order of April 19, 1974, as amended, Plaintiffs and Defendants submit this Final Pre-Hearing Order.

A. STIPULATION OF UNCONTESTED FACTS

1. The Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief alleging that certain parts of the Pennsylvania Mental Health and Mental Retardation Act of 1966 which permit the commitment of persons eighteen years of age and under to mental health facilities on a different basis than other persons and without notice, hearing, right to counsel and other procedural safeguards conflict with the Due

Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.

2. Jurisdiction is properly conferred upon and assumed by the court. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§2281 and 2284.

3. This action shall be maintained as a class action under Rule 23(b) (1) and (2) of the Federal Rules of Civil Procedure on behalf of the class comprised of all persons eighteen years of age or younger who have been, are or may be admitted or committed to mental health facilities in Pennsylvania pursuant to the challenged provisions of the state mental health law (i.e., 50 P.S. §§4402 and 4403). This definition of the class is without prejudice to the possibility that it may be amended or altered before the decision on the merits herein.

4. Pursuant to Rule 17(c) of the Federal Rules of Civil Procedure, David Ferleger, Esquire, Counsel for the Plaintiffs, was and is appointed guardian ad litem for plaintiffs and their class and he appears for them in this action and maintains it in their behalf.

5. Defendant Jack B. Kremens, Hospital Director of Haverford State Hospital, is sued as representative of the directors of all mental health facilities in Pennsylvania, all of which are under the authority and supervision and regulation of Defendants Wohlgemuth and the Deputy Secretary for Mental Health and Mental Retardation.

6. The questions of law and fact involved are:

a. Are the representative parties, and their class, admitted or committed to Haverford State Hos-

pital and other mental health facilities pursuant to the challenged statutory provisions?

b. Are the representative parties, and members of the class, admitted or committed involuntarily?

c. Do Defendants operate, execute and enforce the challenged statutes?

d. Are the challenged statutes contrary to the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution?

7. Plaintiff Kevin Bartley is a citizen of Pennsylvania, age 16 at the filing of this action, having been born November 4, 1956.

8. Plaintiff Steve Gentile is a citizen of Pennsylvania, age 18 at the filing of this action, having been born March 20, 1954.

9. Plaintiff Leslie Levine is a citizen of Pennsylvania, age 15 at the filing of this action, having been born October 8, 1957.

10. Plaintiff Vicki Mathews is a citizen of Pennsylvania, age 15 at the filing of this action, having been born September 10, 1957.

11. Plaintiff Mark Weand is a citizen of Pennsylvania, age 15 at the filing of this action, having been born June 13, 1957.

12. Haverford State Hospital is a mental health "facility" under Section 102 of the Pennsylvania Mental Health and Mental Retardation Act of 1966. (Hereafter, the "Act"). It receives admissions and commitments of

persons, including Plaintiffs and their class, under said Act.

13. Defendant Jack B. Kremens is Hospital Director of Haverford State Hospital and is charged with supervision and administration of the facility (§§102 and 103 of the Act). It is to Kremens or his delegates that applications for admission, commitment and release must be made. (§§402(b), 403(b) and 403(c) of the Act).

14. Defendant Helene Wohlgemuth is the Secretary of Public Welfare of the Commonwealth of Pennsylvania which department has the power and duty to enforce the Act and to make all regulations necessary and appropriate to the proper accomplishment of the Act and to operate and assign functions to all state facilities. (§§201(2) and 202(a) of the Act).

15. The Defendant Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania has general authority to supervise and regulate mental health facilities within Pennsylvania.

16. Plaintiff Kevin Bartley was committed to Haverford State Hospital on November 30, 1971 under §403(a)(2) of the Act.

17. He was committed by his mother although he did not wish to enter the hospital.

18. Kevin Bartley was, and still is critical of the hospital and believes that some of the hospital's regulations are arbitrary, that the staff played favorites with patients, that unnecessary punishments were imposed for minor rule infractions, and that patients were transferred to locked wards as punishment for mere allegations of wrong-

doing, without hearing or proof. Defendants admit that Bartley was critical as above but deny the validity of his beliefs.

19. Plaintiff Steve Gentile was committed to Haverford State Hospital, allegedly involuntarily, on August 24, 1971, by his father under Section 403 (a) (2) of the Act.

20. Plaintiff Leslie Levine's mother committed her, allegedly involuntarily, to Haverford State Hospital on October 11, 1972, under Section 403 (a) (2) of the Act.

21. Levine's parents are divorced; her father is remarried and living in Florida; she would have (at the time of her commitment and the time this action was filed) liked to have been with her father because she gets along well with him. Every time she visits with her father, her behavior is excellent. Levine's difficulties in relating to her mother resulted in her commitment. Hospital records indicate Levine threatened the lives of her mother and sister and that she has a "personality disorder."

22. Plaintiff Vicki Mathews was committed to Haverford State Hospital, allegedly involuntarily, on August 9, 1972 by her parents under Section 403 (a) (2) of the Act.

23. Plaintiff Mark Weand was admitted to Haverford State Hospital, allegedly involuntarily, on June 23, 1972 by his mother under Section 402 (a) (2) of the Act.

24. Weand did not wish to become a mental patient and has informed Defendants' agents and employees of his desires to leave which occurred on December 1, 1972.

25. Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. §4402) provides as follows: (Those parts which are challenged by

Plaintiffs as unconstitutional are emphasized by underlining [italics])

Section 402. Voluntary Admission; Application, Examination and Acceptance; Duration of Admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) *Except where application has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger,* any person voluntarily admitted shall be free to withdraw at any time. *Where application has been made under the provisions of Section 402(a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.*

(d) omitted here.

26. Section 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. §4403) provides as follows: (Those parts which are challenged by

Plaintiffs as unconstitutional are emphasized by underlinings [italics])

Section 403. Voluntary Commitment; Application, Examination and Acceptance; Duration of Commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, *or after the applicant or his successor has given written notice of intention or desire to remove the detained person.*

(d) omitted here.

27. The only other provisions for civil commitment to a mental health facility provided by Pennsylvania law are:

a. Section 404 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §4404, which permitted commitment of persons upon application of third parties (including parents, guardians, individuals standing in loco parentis, etc.) upon application with certificates of two physicians. Because this section was in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution, this section has been declared unconstitutional. *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971).

b. Section 405 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §4405, permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than ten days.

c. Section 406 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §4406, permits involuntary commitment of persons, regardless of age, upon petition to the state court of common pleas, and after hearing and examination. The respondent to such petition has the right to notice of hearing, the right to counsel and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

28. Voluntary patients over eighteen years of age enter facilities under the Act on their own volition and un-

der Section 402 or 403 and may leave and discharge themselves either at any time (Section 402) or upon proper written notice (Section 403). Plaintiffs and their class are denied such entrances and separation from the facility by the challenged portions of these sections of the Act.

29. A person over eighteen years of age who does not wish to enter a facility may be placed there involuntarily only upon the order of a court pursuant to the procedures, including a petition, notice, and hearing, mandated by Section 406 of the Act.

30. The county in which Polk State School and Hospital is located would have had only 33 additional hearings in 1972 for the juveniles who were instead admitted "voluntarily" by a parent or guardian under the challenged portions of the Act. Similarly, Whitehaven State School and Hospital patients would have required only 87 hearings.

31. The tables attached to this Order and numbered 1, 1a, 2, 2a, 3, 3a, 4 and 4a are true and correct statistical summaries of data submitted by Defendants herein, for the purposes of this action, they are accepted as correct. These tables do not reflect all the data given in response to the interrogatories and questionaire.

32. At the June 15, 1973 meeting of the Department of Public Welfare Advisory Committee for Mental Health and Mental Retardation, the committee requested that the Governor's Task Force on Mental Health of Children and Youth consider the rights of children to refuse treatment.

33. The Task Force's report, dated August 6, 1973, of the meeting of July 18, 1973, stated:

It was agreed that any child has a right to know why he was being institutionalized, that he should be given all of the relevant information regarding such a process, that he had a right to participate in the decision making and that he had a right to have somebody speak up for him. When the child's desires and interests conflict with those of the parents, it appeared highly appropriate that the child should be represented by counsel, rather than his parents. . . . Essentially there was agreement that the child's best interests would be served by holding a *hearing prior* to any commitment to an institution, rather than (as has been suggested by the Department of Public Welfare) a review of the circumstances after institutionalization. The principal reasons were:

(1) The Task Force felt that commitment without a hearing and without the safeguards of due process, representation of counsel and fair notice represented an unacceptable deprivation of liberty.

Young people with emotional problems should have the same rights under the law as delinquents. In those cases where juveniles are accused of delinquent conduct which would constitute a crime if committed by an adult, the court's have rules for procedural guarantees derived from criminal law. These may become the rule in a larger variety of cases having to do with "truancy" or "incorrigibility".

(2) The Task Force noted that the reasons for parents seeking institutionalization in a mental health facility for young people are often similar to or the same as reasons why children are brought up on delinquency charges, i.e., young persons may be refusing

parental authority, involved with drugs, not attending school, etc. The path chosen (mental health or delinquency) is often more a matter of the advice given to parents by social agencies, rather than a significant decision about delinquency or non-delinquency of the youth.

Under this direction juveniles would have such procedural guarantees as written notice of the charges in advance with ample time to respond, right to representation by counsel, privilege against self-incrimination, availability of witnesses for confrontation and cross-examination, and the evidence must prove the charge beyond a reasonable doubt.

(3) Disagreements exist among psychiatrists regarding diagnosis and the need for institutionalization. Research has indicated that when adults request subsequent review (even though already institutionalized) that approximately half are discharged. The implication is that persons may be committed when the justification does not exist "beyond the reasonable doubt." A prior hearing at least forestalls the unjustified deprivation of liberty.

(4) When the review process is followed, i.e., after institutionalization, it is recognized that the patient is at a disadvantage:

(a) He may have been subjected to a variety of institutional pressures, to medication, and to treatment which reduces temporarily his capacity to make the best presentation.

(b) The patient can not "shop around" to find a variety of advice and counsel from sources of his own choosing.

(c) A person in an institution, particularly a child or young person, away from his familiar and protective environment for a period of time may become somewhat disoriented and less judgmental.

(5) A young person ought to have the right of the *least drastic treatment alternative*. Before commitment to an institution is decided upon it should be clear that all other alternatives have been explored: outpatient treatment, partial hospitalization, placement in a foster home or some alternative environment.

(6) It is recognized that problem behavior on the part of a young person is often linked to family dynamics. Commitment tends to place the burden for the disturbed behavior on the young person. When a young person is institutionalized, there is rarely an orientation on the part of the hospital to require parental participation in the treatment process. In contrast, outpatient treatment often may require parental involvement.

The Task Force recognized that commitment does not necessarily mean that treatment will take place. In keeping with previous principles of the Task Force the position was taken that commitment should not take place unless there was a guarantee of appropriate treatment.

Recognizing the slow process of the courts, in recommending the use of a prior hearing, it was discussed further that consideration be given to a quasi-legal structure with special expertise to make these decisions. Analogous structures are the Civil Service Commission and the Human Rights Commission.

In summary, it was the essential position of the Task Force that in order to properly safeguard the rights of youth, when there is a question of the need for institutionalization, a prior hearing should be held to adjudicate the matter, with appropriate Due Process safeguards, preferably before a specially constituted quasi-legal body rather than the existing court structure.

B. AGREED STATEMENT OF CONTESTED ISSUES OF FACT AND OTHER CONTESTED MATTERS

1. *Witnesses*

Defendants propose, in addition to those persons named in their earlier submission and listed below, to call as expert witnesses Dr. Derek Miller of the University of Michigan and Dr. James Masterson of the Cornell Hospital in New York.

Plaintiffs' position is that unless the Defendants prove that these persons were unavailable since the Court's Order of April 19, 1974, Plaintiffs object to their naming further witnesses.

Defendants' position is that, in their earlier submission, they stated that they were "attempting to secure other expert witnesses who have been up to this time, unavailable." Thus, they wish to have these two experts testify.

2. *Need for Hearing*

Plaintiffs' position is that there may be factual differences among expert witnesses regarding whether certain legal procedures may or may not be medically therapeutic for juveniles and whether and at what age juveniles may psychiatrically be thought fit to make application for treatment. It is the position of the Plaintiffs that these factual differences are irrelevant and not essential to the Court's determination of the legal and Constitutional questions posed by this action. A memorandum to that effect has been filed.

Defendants object to this in that expert testimony would reveal that there are contested issues of fact which are critical to the legal issues posed by this lawsuit.

3. *Discharge and Readmission Data*

Defendants propose as facts to be agreed upon the discharge date of each named plaintiff and the readmission date of any of the named plaintiffs as well as the petitioner, if any, and the precipitating behavior causing readmission. This information will be obtained from their medical charts.

Plaintiffs object as this is a class action; the discharge dates and readmission data for the named plaintiffs are irrelevant and not essential to determining the legal issues herein. Also, Plaintiffs object that these proposed facts have not themselves been submitted to the Court or to Plaintiffs.

4. *Monetary Liability*

Defendants submit that there is no monetary liability of any Defendants herein. See *Edelman v. Jordan*, U.S. (March 25, 1974).

Plaintiffs object on the grounds that *Edelman v. Jordan* does not eliminate all "monetary liability" by Defendants. That case dealt with equitable restitution of retroactive welfare benefits. Plaintiffs herein, however, do not now seek damages but will, at the appropriate time, seek attorney's fees and guardian compensation.

5. *Data in Interrogatory and Questionaire Replies*

Typed below are a number of paragraphs containing facts and data from the responses to interrogatories and questionaires submitted by Defendants. The language within each paragraph has been agreed to by the parties. There is disagreement on whether these paragraphs alone are sufficient or otherwise admissible. The positions of the parties are given below, followed by the paragraphs in question.

Defendants' Position

Defendants object on the grounds that they are an analysis by the Plaintiffs' attorney of the data collected by Defendants. As such, the Best Evidence Rule precludes such an analysis when the data itself is readily available to the court. Furthermore, since this court, in the instant case, is the trier of facts, only Your Honors are entitled to analyze the data and draw conclusions. We respectfully disagree with Mr. Ferleger's analysis.

Defendants further object to Plaintiffs' use of the analysis without the complete medical record of each patient before the Court. For the sake of administrative ease it is most common for these state facilities and private facilities which responded to Defendants' questionaire to record only the overt act precipitating the hospitalization of the patient without any further explanations. However, in the overwhelming majority of cases involved, the patient is suffering from some further mental infirmity such as mental retardation, which will become quite apparent to the court upon reviewing the complete medical chart of the patient, which we are willing to provide for this Honorable Court.

Defendants object to paragraph 1 below on the grounds that it is misleading to the court. Defendants agree that the records of the patients state these grounds for admission. However, an examination of the total record of each patient would in most instances reveal a further infirmity requiring hospitalization. Furthermore, all patients admitted to Pennhurst, Polk, and Western State Schools and Hospitals are also suffering from mental retardation. Moreover, all those listed from the private facilities mentioned in paragraph 1 have not objected to their hospitalization.

Plaintiffs' Position

Plaintiffs' position is that the paragraphs below contain portions of the responses to interrogatories filed and sworn to by Defendants. These give the Court a fuller context in which to view the grave issues presented in this action.

Plaintiffs have conducted an analysis of the voluminous data presented; Defendants have not. Plaintiffs have no objection, of course, to the Court's accepting as part of the record the full responses to the interrogatories and questionaires. It is for the convenience of the Court and the parties that these paragraphs are submitted for stipulation.

However, the present suggestion of Defendants that "the complete medical record" of hundreds or thousands of patients be dragged into court is ludicrous and untenable. We suggest the Court rely on the data which the Defendants were ordered to produce and which they agreed to produce.

The very reason why the short explanations in the interrogatory replies are the matters essential to the Court

is given in the Defendants' own words: THE REPLIES: "record only the overt act precipitating the hospitalization of the patient . . . ." The point of this action is that the "overt act" is a factual question which must be decided at a judicial hearing rather than decided by parents or agencies with often adverse interests or by medical personnel. In this light, the medical record amassed *after* admission is irrelevant.

Of course, many institutionalized persons have emotional problems or are retarded—this is also true for non-institutionalized persons. The issue before the Court, is the process for initiating institutionalization procedures and the crucial aspect is the factual situation which sparked the process and the procedures which flow therefrom.

Defendants state they "agree that the records state these grounds for admission." There is no reason to bar from the record these matters.

Defendants' Position on Private Facilities Mentioned

Defendants admit to paragraphs 5, 6, 7, 8 below. However, the state only licenses private facilities and does not supervise these facilities in the same way that they supervise the state mental hospitals and state schools and hospitals. Consequently, the state cannot be held liable should a private facility [be] in violation of the Mental Health and Mental Retardation Act of 1966. The injured party may bring a lawsuit against any such private facility.

Plaintiffs' Position on Private Facilities Mentioned

Regarding so-called private facilities, Defendants attempt to claim that they are somehow not involved and do not supervise them. This is absolutely incorrect.

The Defendants have the power to regulate all facilities, 50 P.S. §4102, and have exercised that power by promulgating *regulations for the private licensed facilities* which require:

> Admission and commitment of patients shall be in accordance with the Mental Health and Mental Retardation Act of 1966 and shall be accomplished by the use of forms developed by the Department pursuant to that Act.
>
> DPW Regulations Title 9100.

Defendants' Position on Paragraph 8

Defendants object to paragraph 8 below on the grounds that it is irrelevant to the issue at hand. This paragraph does not relate to the constitutionality of the statutes involved, but rather, discussed alleged violations of the statute by private facilities which are not under the state's direct control.

Plaintiffs' Position on Paragraph 8

This paragraph demonstrates how the rights of the class here are violated by facilities which, while subject to the mental health act, determine to ignore the law. Defendants are responsible for the licensing and supervision of these facilities yet do nothing to stop their unconstitutional behavior in admitting and committing juveniles without a hearing and without even following the procedures supported by defendants.

1. Children have been institutionalized in Pennsylvania mental health facilities for the following reasons as noted by the institution. The number following the name of the institution is the facility's patient number.

Runaway, incorrigible (Pennhurst #402)

Violent episodes (Polk #13,173)

Hostile, attacked children, attempted to set home on fire (Polk #13,077)

Robbed gas station (Mental Health Center of Carbon, Monroe, Pike Counties #M-0-0543)

Stole truck, car (Mental Health Center of Carbon, Monroe, Pike Counties #M-0-1210)

Member of gang which participated in robbery (Thomas Jefferson University Hospital #360233)

Stealing (Northwestern Mental Health Center #628)

Involved with altercation with ten year old girl whom he chased and struck (Allentown State Hospital #25380)

Firesetting (Northwestern Mental Health Center #620)

Delinquent behavior (Northwestern Mental Health Center #637)

Firesetting (Northwestern Mental Health Center #61)

Arson (Fairmount Farms #16187)

Firesetting, stealing (Western #281)

Runaway (Fairmount Farms #16187)

Runaway, truancy, delinquent behavior (Western #288)

The courts have committed juveniles to these same institutions for similar reasons including the following:

Aggressive behavior toward family. Refusal to attend school. Excessive demands of attention at home. (Western #285)

2. Mental health facilities sometimes cooperate with parents and relatives in doing what Judge (now Chief Justice) Burger, in a dissenting opinion, calls "farming out their kindred into mental institutions for motives not always worthy." *Kent v. United States,* 401 F.2d 408, 416, footnote 4 (D.C. Cir. 1968).

3. Children have wound up at institutions for the following reasons, in addition to their being mentally retarded:

Interim placement while family was on vacation (Polk #13,212)

A mother placed her child at Western because "father out of household in the military." (Western #144)

Hyperactivity interfered with the routine of household and disturbed family members. (Western #15)

A newly widowed father was able to place a youngster at Western because he was allegedly "unable to care for child." (Western #67)

Western accepted another child from a mother because of "desertion of father". (Western #131)

In another case, a mother and a father who themselves had emotional difficulties institutionalized their child because they held the "problems of the child . . . responsible for their emotional adjustment." (Polk #12,-82)

One institution accepted a juvenile because "difficult to care for Loretta and her presence confines the parents in the home." (Western #73)

A boy named Joseph left "no free time for mother . . ." (Western #13)

Family problems (Philhaven #5647)

Family conflicts (Institute of Pennsylvania Hospital #94-94-33)

Family problems, needed separation from the family (Western State, no number given)

Unmanageable at home, attitude of bold indifference, resents all discipline, compulsive eating (Allentown State Hospital #25741)

Problems with family (Philhaven Hospital #5692)

Began to have trouble handling his anger and hurt feelings towards his parents. Took these feelings to school with him. (Allentown State Hospital #25520)

Runaway, conflict with parents (Institute of Pennsylvania Hospital #94-93-74)

Physical burden on mother who has three additional children. (Western #36)

One of three mentally retarded in the family. Coping with this problem is simply too much for the family. (Polk #13,103)

Because argumentative and wanted to stay out of school. Patient's mother overdosed and was hospitalized. Patient then had to be hospitalized. (Warren State Hospital, no number given)

Neglect, Social Deprivation (Stillmeadow Home for Exceptional Children #1138)

Neglect, unstable home environment (Stillmeadow Home for Exceptional Children #1138)

Mother has tuberculosis (Western #129)

Emotional instability of mother (Western #127)

Hospitalization of mother is apparent reason for admission (Polk #11,985)

No serious behavior problem; admitted due to parents' inability to provide a satisfactory home environment (Laurelton #42)

Quite active and destructive. Illegitimate (Western #286)

Sometimes hyperactive. Illegitimate (Western #288)

Illegitimate. Inadequate mother (Western #227)

4. Polk accepted a young boy because "He has no playmates, planned activities, exercise. Presently he does nothing except sit in school and in front of the T.V. at home." (#12836)

5. Three children were committed to mental hospitals because of physical ailments. At Saint Francis' Hospital one child was committed for ulcerated colitis (#13-58-69); another for psychosomatic complaint (#11-81-06); a third was put in the Institute of the Pennsylvania Hospital for weight loss (#94-88-05).

6. There are five children in Saint Francis' Hospital for not going to school. This list is as follows:

school phobic (#12-87-29)
school phobic (#12-80-40)
school phobic (#11-17168)
non-school attendance (#14-18-89)
non-school attendance (#14-57-10)

7. A partial list of juveniles committed for drug related activities is as follows:

Mental Health Center of Carbon, Monroe and Pike Counties:

Overdose (#M-0-1174)
Overdose (#M-0-1165)
Drugs (#Z-0-1004)

McKeesport Hospital:

Medical overdosage (#S.K.)
Medical overdosage (#R.M.)
Medical overdosage (#R.W.)
Medical overdosage (#R.K.)
Medical overdosage (#T.G.)
Medical overdosage (S.C.)
Medical overdosage (T.S.)

Fairmount Farm:

Drugs (#16155)
Drugs (#16147)
Drugs (#16027)

Institute of the Pennsylvania Hospital:

Drugs
(#'s 94-90-72, 94-95-23, 94-93-00,
94-94-92, 94-93-52, 94-91-42,
94-95-32, 94-95-57, 94-95-87)

One juvenile has even been committed for a "*fake* drug overdose." (St. Francis General Hospital #11-85-22)

8. Mental health facilities are required by the Mental Health Act to receive patients *only* pursuant to the statutory provisions of the statute. However, all facilities for which data was provided admitted that, rather than using the proper provisions of the law they accept mentally ill juveniles as "general admissions." This illegal

method of commitment denies to juveniles the presently scant protections of Sections 402 and 403 and also denies them the protection of the new regulations the state has adopted. By going outside the Mental Health Act, the patients' rights (Section 423) need not be endorsed and other rights are denied, e.g., the right to be discharged when treatment is completed (Section 418), the right to leaves of absence (Section 419), the right to review by the Department (Section 420). These are the facilities which presently act in this improper manner:

Happy Hill
Don Fuanella School
Saint Mary of Providence School
Ivy Mansion for Exceptional Children
The Evans School
Clifford Nursing Home
Camp Hill Special School Inc.
Grenwich Home for Children
Refuge Home for Children
Merry Acres
Pleasant Manor Inc.

C. WITNESSES TO BE CALLED AT HEARING

1. *Expert Witnesses of Plaintiff*

1. Henry Kandler, M.D.
Assistant Professor
Einstein School of Medicine
124 E. 84th Street
New York, N.Y. 10028

2. Michael A. Ingall, M.D.
Medical Director
Providence Mental Health Center
355 Broad Street
Providence, R.I.

3. Eli Messinger, M.D.
66 W. 87th Street
New York, N.Y. 10024

2. *Other Witnesses of Plaintiff*

Kevin Bartley
Haverford State Hospital
Haverford, Pa. 19041

3. Plaintiffs' expert witnesses will testify (if the Court determines that it wishes to hear such expert testimony) regarding their experience in psychiatry, and in the treatment of juveniles, that parents and agencies often abuse their authority to commit without a hearing, that hearings would not be anti-therapeutic for juveniles, that there is no psychiatric justification for prohibiting juveniles from personally applying for admission voluntarily.

4. Evidence to be given by Kevin Bartley will include the manner of his commitment to Haverford State Hospital and the circumstances surrounding it.

5. *Expert Witnesses of Defendants*

1. Herman Staples, M.D.
24 Green Valley Road
Wallingford, Pa. 19806

2. Levon Tashians, M.D.
Institute of Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa. 19139

3. Mark Forman, M.D.
Medical Director
Child Psychiatry Division
St. Christopher's Hospital
Philadelphia, Pa.

4. Lance Wright, M.D.
Institute of Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa. 19139

5. James Gibbs, M.D.
Director of Child and Adolescent Psychiatry
Sheppard-Pratt Hospital
Baltimore, Md. 21215

6. Barbara Armstrong, M.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

7. Aaron Smith, Ph.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

8. Jack Kremens, M.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

6. Defendants' expert witnesses will testify regarding their experience in psychiatry and in the treatment of juveniles, that the current procedure utilized by the State of Pennsylvania is sound and that the best interests of the juvenile would not be served if it would be otherwise.

D. EXHIBITS TO BE OFFERED IN EVIDENCE—AGREED EXHIBITS

1. Plaintiffs' Exhibit 1—Sealed affidavits of two juvenile mental patients, describing the facts of their commitment, previously filed of record.

2. Defendants' Exhibit 1—Questionaire dated May 31, 1973 submitted to all state schools and hospitals and to all state mental hospitals.

3. Defendants' Exhibit 2—Answers to the above Questionaire submitted by all of the respondents (already filed of record).

4. Defendants' Exhibit 3—Act of October 20, 1966, entitled "The Mental Health and Mental Retardation Act of 1966", 50 P.S. §4101 et seq.

5. Defendants' Exhibit 4—Regulations, previously filed of record, adopted by the Department of Public Welfare in September of 1973 governing the commitment procedure of minors under 50 P.S. §§4402 and 4403. These adopted regulations were published in the Pennsylvania Bulletin, Volume 3, No. 37, September 1, 1973.

E. EXHIBITS TO BE OFFERED IN EVIDENCE NOT AGREED UPON

1. Plaintiffs' Exhibit 2—Document entitled "Child's Right to Refuse Treatment," which document is the Report of the Task Force on Mental Health of Children and Youth, requested by the Department of Public Welfare Advisory Committee on Mental Health and Mental Retardation on June 15, 1973 and submitted to said Advisory Committee on August 6, 1973.

2. Plaintiffs' Exhibit 3—Affidavit of Dr. Leon Ginsburg, Dean, University of West Virginia School of Social Work, previously filed of record. Dr. Ginsburg is leaving for South America at the beginning of August, 1974 and will be there at the time of the hearing.

3. Plaintiffs' Exhibit 4—Affidavit of Dr. Joel Finer, Monthaven Mental Health Center, 2804 Third Avenue, Bronx, N.Y. 10455. Dr. Finer will be unavailable for trial in September, 1974.

4. Defendants object to Plaintiffs' Exhibit 2 above on the grounds that it is irrelevant and object to Exhibits 3 and 4 above on the grounds that they are unable to cross-examine affiants.

F. LIST OF DEPOSITIONS AND PORTIONS THEREOF TO BE OFFERED IN EVIDENCE

1. Deposition of Dr. Barbara Armstrong, taken on March 2, 1973. The exhibit attached to this order lists and describes those portions of the deposition which the parties have agreed to be included and those portions agreed to be excluded. The attached exhibit also indicates those portions of the deposition on which the parties are in disagreement as to which portions should be omitted and which included. The basis for these objections and disagreements is a claim by both parties that the portions are irrelevant.

2. Deposition of Dr. Max Sugar, to be taken July 31, 1974 by the Defendants. It is expected that portions to be admitted and to be excluded will be agreed upon by the parties.

G. SEPARATE STATEMENTS OF CONTESTED ISSUES OF LAW

The parties do not agree on the contested issues of law herein. Their separate statements are given below.

1. The Plaintiffs' contested issues of law are:

a. Do the challenged portions of the Mental Health and Mental Retardation Act of 1966, and Defendants' actions in operating, enforcing and executing the same, deprive Plaintiffs and their class of liberty without Due Process of Law in violation of the Fourteenth Amendment to the United States Constitution in that Plaintiffs and their class are detained and incarcerated in mental institutions without:

1. the right to notice;

2. the right to a pre-commitment hearing;

3. the right to counsel and, if indigent, appointment of counsel;

4. the right to present evidence and testimony on their own behalf;

5. the right to subpoena witnesses and documents;

6. the right to confront and cross-examine witnesses against them and those who wish them to enter a facility;

7. the right to independent expert examination and assistance;

8. the right to be involuntarily detained only upon a decision of a judicial officer in a non-emergency context;

9. the right to be involuntarily detained only upon a decision that they are in need of care, treatment or observation, and are dangerous to themselves or others beyond a reasonable doubt;

10. the right to appeal and review, including provision for assistance of counsel and record and transcript without cost if appellant is unable to pay the cost thereof;

11. other procedural safeguards.

b. Do the challenged portions of the Mental Health and Mental Retardation Act of 1966, and Defendant's actions in operating, enforcing and executing the same, deprive Plaintiffs and their class of Equal Protection of the Laws in violation of the Fourteenth Amendment to the United States Constitution in the following manner:

1. The Act creates two classes of admittees or committees who desire to receive mental hospitalization and treatment. These classes are distinguishable only on the basis of age. One class (the juveniles) can receive such hospitalization and treatment only on the application of another party. The other class (those above the age of eighteen years) can receive such hospitalization and treatment upon their own application. There is no adequate state justification for this arbitrary classification.

2. The Act creates two classes of admittees or committees who do not desire to receive mental hospitalization or treatment. These classes are distinguishable only on the basis of age. One class (the juveniles) can be forced to receive such hospitalization and treatment without notice or hearing and with no procedural safeguards of any kind. The other class (those above the age of eighteen years) cannot be forced to receive such treatment without a judicial hearing, notice and other procedural protections. There is no adequate state justification for this arbitrary classification.

2. The Defendants submit that the contested issues of law is whether or not Section 402 and 403 of the Mental Health and Mental Retardation Act of 1966, including regulations adopted September 1, 1974, are violative of the due process and equal protection clauses of the Fourteenth Amendment to the United States Constitution.

The above constitutes the agreements and disagreements of the parties as finalized at a meeting between counsel in Harrisburg, Pennsylvania on July 25, 1974 pursuant to the Order of Court of April 19, 1974, as amended. Although the original Order specified that this final order was to be filed by July 24, 1974, by agreement of counsel, with the concurrence of Judge Huyett, it is being filed on July 26, 1974, by the Plaintiffs in accordance with Paragraph 2 (d) of the Order of April 19, 1974.

Respectfully submitted,
(s) David Ferleger,
David Ferleger, Esquire
Attorney and Guardian Ad Litem for Plaintiffs

July 26, 1974

MENTAL PATIENT CIVIL LIBERTIES PROJECT

Suite 1407, 1315 Walnut Street
Philadelphia, Pa. 19107
215-735-8409

With: Peter Brown
David Norris

EXHIBIT

Portions of Deposition of Barbara Armstrong March 2, 1973, to be submitted to the Court

Portions Agreed upon by Plaintiffs and Defendants:

Noted below, for each page of the deposition, are those portions of the deposition upon which the parties have been able to reach agreement. For these portions, the Court's direction to exclude colloquy and extraneous matters has been heeded, with success.

A second list follows, denoting those portions of the deposition upon which the parties have not been able to reach agreement, even while attempting to follow the Court's instructions.

The following abbreviations are used below: "D" for delete, "I" for include, and "L" for the line of the actual text on the particular page (spaces excluded). The number at the left margin is the page number. Where no lines are indicated, the entire page is deleted or included.

1. I
2. D after L 9
3. D
4. D
5. Disagreed (second list)
6. D
7. D; I only question by Mr. Ferleger
8. D to L 10
9. I
63. I L 15-20
64. Disagreed
65. Disagreed
66. D L 4-7, 22-24
67. I L 17-"Once . . ."-L 20
68. I 8-22
69. D L 10-11
70. I L 6
71. I L 13-16
72. I L 11-18

10. Disagreed
11. Disagreed
12. I to L 13; D L 14; I L 15, 16; D to bottom
13. I L 3-15
14. D to L 2; D L 11, 12
15. Disagreed
16. I L 6-9
17. I L 13-15; I L 22
18. Disagreed
19. D to L 6
20. I to L 6; I L 17-20
21. D to L 17
22. D L 4-9
23. I to L 5
24. I
25. D L 8-17
26. D L 22-24
27. D L 4, 7, 17-20
28. I to L 7
29. Disagreed
30. I L 20-23
31. I
32. D
33. D
34. D to L 13
35. I
36. I
37. D L 5-6, 10-21
38. D L 21-24
39. D L 7-14, 23-24
40. I to 13
73. I L 6-9, 20-24
74. I
75. D L 13-20
76. I
77. D L 16-17
78. I
79. I
80. D to L 8; I from "I would"
81. Disagreed
82. I
83. I
84. D L 21
85. I to L 10
86. Disagreed
87. Disagreed
88. Disagreed
89. Disagreed
90. D
91. D to L 5
92. I
93. D L 3-13, 17-20
94. I
95. D L 21-23
96. D L 1
97. I to L 8
98. D to L 19
99. I
100. I
101. I to L 18
102. D to L 5
103. Disagreed
104. D L 1-5, 7
105. Disagreed

41. Disagreed
42. D to L 17
43. D L 5-6
44. Disagreed
45. I
46. I to L 16
47. D L 1, 19
48. D L 20-24
49. I L 6-14
50. D L 1
51. D L 3-4
52. Disagreed
53. Disagreed
54. I 7-14, 18-24
55. I 1, 8-14
56. Disagreed
57. Disagreed
58. Disagreed
59. I L 1-22; D L 22-24
60. D
61. Disagreed
62. D L 1-2, 20-24
106. Disagreed
107. Disagreed
108. Disagreed
109. Disagreed
110. I L 1-14, 18-24
111. I
112. Disagreed
113. D to L 5
114. D L 18-19
115. D L 9-18, 22-24
116. I
117. I
118. Disagreed
119. I L 13-17
120. D to L 16
121. I
122. I
123. D to L 10
124. D L 24
125. I
126. Disagreed
127. D L 8
128. I

Noted below are those portions of the deposition upon which the parties have not been able to reach agreement. Plaintiffs' and Defendants' selected deletions and inclusions are denoted in separate columns at the right of the page, opposite the corresponding page number.

	Plaintiffs	*Defendants*
5.	D to L 14 D last 3 lines	D to L 14 D last 5½ lines beginning with "I . . ."

10.	I 1-4; D L 5-12; I L 13-15; D to bottom	Irrelevant
11.	D to L 14	D to L 20
15.	I L 5-19	Irrelevant
18.	D	I
29.	D	I
41.	I L 10-22	D L 19-22
44.	D L 2-6; Begin at "do you"; D L 13-21	I
52.	I	Irrelevant
53.	D L 3-6, 21-24	D 21-24
56.	I to L 4	Object
57.	I L 10-24	I 10-21
58.	D L 1	D
61.	I L 4 from "I will" to L 9	I L 5 beginning with "I certainly . . ."- L 9
64.	D to L 21	I L 2-7
65.	D L 4-5	I
81.	I	Irrelevant
86.	I to L 7	Irrelevant
87.	D to L 21	Irrelevant
88.	D to L 22	Irrelevant
89.	I to L 8	Irrelevant
103.	I to L 9	I to L 16
105.	I to L 16	I to L 16; D L 16-20; I L 20-24
106.	D	I
107.	D to L 14; I from "Speaking"	I
108.	D L 3-5	I L 1; D L 3-5; I remainder

109.	I to L 20	I
112.	I	I L 1-8
118.	D L 21-24	Irrelevant
126.	I	D L 14-18

TABLE 1 -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 402	403	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other family Members*	Misc.	Not Given**
[illegible]	341	[illegible]	0	[illegible]	[illegible]	0	1	1	1
[illegible]	[illegible]			596	25	0	0	0	0
[illegible]	[illegible]	1		98	5	1	2	0	4
Cresson	[illegible]	[illegible]	[illegible]***	209	25	[illegible]	5	1	0
Selinsgrove	[illegible]	[illegible]	[illegible]	196	7	[illegible]	3	0	20
Western	291	3	[illegible]	257	7	4	5	11##	5
Laurelton	70	4	[illegible]	53	6	0	2	1	0
Whitehaven	169	0	0	123	7	0	2	1	36
[illegible]	214	0	[illegible]	100	1[illegible]	[illegible]	2	0	0

* "Other family members" include grandparents, uncles, aunts, brothers.
**There is no explanation for the facilities' so frequently leaving blanks in their replies.
***These two persons are transfers from other facilities; they are listed as "voluntary" but no applicant with appropriate legal section is given.
\#\# These 11 persons' applicants are listed as "Entrustment Agreement."

All entries refer to the number of cases involved.

TABLE 1a -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

Name of State School or Hospital	Type of Commitment 402	403	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other Family Members	Misc.	Not Given
Dixmont	1	[illegible]	[illegible]	?	?	?	?	?	3
Allentown	[illegible]			50	5	0	1	0	27
Hollidaysburg	[illegible]	3	[illegible]	2	0	0	0	1	0
Harrisburg NH & R Center		[illegible]		1	0	0	0	0	0
Somerset		[illegible]	[illegible]	6	2	0	0	0	0
Farview		[illegible]	0	[illegible]	0	0	0	0	0
Philadelphia	[illegible]		[illegible]	[illegible]	0	0	0	1	1
Warren	11	[illegible]	[illegible]	8	2	0	0	2	2
EPPI	[illegible]		0	15	4	0	0	0	0
Embreeville	[illegible]		[illegible]	20	9	0	0	0	0
Norristown	1[illegible]		0	1[illegible]	0	0	0	2	0
Torrance	[illegible]	5	0	3	0	0	1	0	1
Wernersville	21	[illegible]		?	?	?	?	?	21
Haverford	13	134	0	?	?	?	?	?	197
Clark Summit	[illegible]	3	0	1	0	0	0	0	1
Retreat	6	4	0	3	0	0	1	0	0
Eastern	211	6	5	?	?	?	?	?	215
Harrisburg St. Hosp.	8	7	0	7	2	0	1	4	1
Danville	22	1	0	17	5	0	0	0	1
Mayville	0	1	0	0	0	1	0	0	0
	4	35	0	34	0	5	0	0	0

TABLE 2 -- COURT COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 406	Not Given**	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other Family Members*	Misc.	Not Given**
Polk	18	0	0	1	7	9	0	1[a.]	0
Ebensburg	12	?	?	?	?	?	?	?	12
Pennhurst	44	3	3[b.]	34	4	1	0	0	11
Dresson	?	0	0	0	0	0	0	0	0
Selinsgrove	3	0	0	2	1	0	0	0	0
Western	5	0	6[c.]	2	3	4	0	1[d.]	1
Laurelton	6	0	0	4	1	0	0	1[e.]	1
Whitehaven	?	0	0	0	0	2	0	0	0
Hamburg	20	0	0	16	2	0	2	0	0

* "Other family members" include grandparents, uncles, aunts, brothers.
** There is no explanation for the facilities' so frequently leaving blanks in their replies.
a. The petitioner was the Superintendent of Polk.
b. These were 3 transfers under Section 416.
c. These 6 were under the 1951 law.
d. The County Mental Health Administrator.
e. "Deputy Administrator of Juveniles and Misdemeanants."

All chart entries refer to the number of cases involved.

TABLE 2a -- COURT COMMITMENTS AND APPLICANT CATEGORY

Name of State School or Hospital	Type of Commitment 406	Not Given	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other Family Members	Misc.	Not Given
Allentown	3	?	?	3	0	0	0	0	0
Hollidaysburg	1	?	?	1	0	0	0	0	0
Harrisburg MH - MR Center			0	0	0	0	0	0	0
Somerset	1	?	?						1
Farview		?	4	0	3	3	0	0	1
Philadelphia	—	?	?						
Warren	26	?	?	0	0	0	0	0	26
EPPI	1	0	0	1	0	0	0	0.	0
Norristown	13	?	?	4	0	1	0	8	0
Torrance	?	0	0	0	0	2	0	0	0
Wernersville	1	0	1	0	0	0	0	0	11
Haverford	3?	0	31	0	0	0	0	0	68
Retreat	1	0	0	0	1	0	0	0	0
Harrisburg St. Hosp.	1?	0	0	3	4	0	0	3	0
Mayview	?	?	?	?	?	?	?	?	?
Danville	6	0	0	?	?	?	?	?	6
Woodville	8	0	0	0	0	7	0	0	1
Eastern	23	0	0	?	?	?	?	?	23
Clark Summit	4	0	0	?	?	?	?	?	4

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TABLE 3

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILITIES

Name of State School and Hospital	TYPE OF COMMITMENT 402	403	406	Not Given
Polk	33	0	0	0
Ebensburg	26	0	0	0
Pennhurst	11	0	30	0
Cresson	41	0	0	0
Selinsgrove	17	2	0	0
Western	55	3	2	0
Laurelton	29	0	2	0
Whitehaven	87	0	2	0
Hamburg	18	0	3	0

•There is no explanation for these omissions in the dat supplied by Defendants.

TABLE 3a

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILITIES

Name of State School and Hospital	TYPE OF COMMITMENT 402	403	406	Not Given
Allentown	65	23	2	
Norristown	17	11	15	
Hollidaysburg	0	2	1	
Somerset	{28}		0	
Farview	0	0	0	0
Philadelphia	9	2	4	
Harrisburg MH & R Center	0	1	0	0
Warren	4	0	12	0
EPPI	17	2	1	0
Torrance	0	4	2	0
Wernersville	12	0	3	0
Waverford (to May 1, 1973)	10	113	24	0
Retreat	3	1	1	0
Harrisburg State Hospital	7	13	14	0
Mayview	0	0	0	(1 awaiting transfer)
Woodville	4	29	7	0
Dixmont	0	0	1	0
Eastern	93	0	20	
Embreeville	10	0	10	
Clark Summit	1	1	2	
Danville	21	0	11	

TABLE 4

OBJECTIONS TO TREATMENT*

Name of State School and Hospital	Objected at or after Commitment	Capacity to O Yes	No
Polk	0	--	--
Ebensburg	3	Remarks on r	
Pennhurst	0	--	--
Cresson	0	--	--
Selinsgrove	16	16	0
Western	15	6	8
Laurelton	7	3	4
Whitehaven	0	--	--
Hamburg	0	0	0

*All the data here are questionable both in terms of their incompleteness and the fact that the replies are frequently qualified by such terms as "no objection on the record" or "don't know."

**The question marks ("?") indicate no reply by the facilities.

The capacity to object is determined solely by the facility without any reported judicial determination of incompetency for that purpose.

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SUMMARIES OF SELECTED PATIENTS

#402

CONFIDENTIAL

This information is privileged and should not be divulged without prior permission of The SUPERINTENDENT PENNHURST STATE SCHOOL & HOSPITAL

Hon. Wm. C. Ferguson

IN THE COURT OF QUARTER SESSIONS OF THE PEACE, OF THE COUNTY OF PHILADELPHIA

JUVENILE COURT

April 4, 1913

Committed to the custody of Eastern Pennsylvania State Institution for the Feeble-Minded and Epileptic, 15 years of age, Feebleminded.

Subject to order of Court.

[Seal]

Arthur D. Brown
Pro-Clerk

CONFIDENTIAL

This information is privileged and should not be divulged without prior permission of The SUPERINTENDENT PENNHURST STATE SCHOOL & HOSPITAL

Eastern Pennsylvania State Institution for the Feeble-Minded and Epileptic

ADMISSION OF MINOR

APPLICATION

In the case of ———————— of Phila. ———— 19—.
Received 2/1/10
Admitted Mar. 19/10

STATE INSTITUTION FOR THE FEEBLE-MINDED AND EPILEPTIC
Spring City, Pennsylvania

APPLICATION FOR THE ADMISSION OF A CHILD UNDER TWENTY YEARS OF AGE

To the Board of Trustees of the Eastern Pennsylvania State Institution for the Feeble-minded and Epileptic:

I, the undersigned Secretary, resident of Philadelphia, County of Philadelphia, State of Pennsylvania, respectfully request that my Ward,* named ———————— and aged 12 years, be admitted to your Institution.

(Signed) [Illegible]
Secretary

Let Every Question Be Answered as Fully as Possible

Question — Answer

1. What is the child's name? ————————.
2. What is the date of the child's birth? Sept. 12th, 1897.
3. Where was he born? Philadelphia.
4. Was he born at the full period of gestation? Yes.
5. Were there any extraordinary circumstances attendant upon the delivery? If so describe them. No.

6. Was the delivery natural or instrumental? Natural.
7. Was the child injured during delivery, especially about the head? No.
8. What has been the general health and the bodily conditions of the child? Fair.
9. What is now the general health of the child? Good.
10. Does he walk? Yes.
11. At what age did he begin to walk? About 18 mos. old.
12. At what age was any mental peculiarity first noticed? About 9 years age.
13. In what manner did this peculiarity first manifest itself? In strange actions.
14. Has the child ever had any accident or injury of any kind? If so, describe it fully, stating age at time of occurrence, and what effects if any, remain. Was sunstruck between age 3 & 4.
15. [Illegible] No.
16. [Illegible] —
17. [Illegible] No.
18. [Illegible] No.
19. [Illegible] √
20. [Illegible] √

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21. [Illegible]
22. Is consciousness apparently lost at each attack?

23. Are the attacks increasing in frequency or becoming more severe?

24. Do the attacks occur more frequently by day or night?

25. What is the greatest number of attacks the child has ever had in twenty-four hours?

26. Was the father of the child subject to fits or tuberculosis? No.

27. Was the mother of the child subject to fits or tuberculosis? No.

28. Was there any known pecularity in the family of the father of the child? That is, were any of the grandparents, parents, uncles, aunts, brothers, sisters or cousins blind, deaf or insane, or afflicted with any infirmity of body or mind?

29. Is there any peculiarity in the form or size of the head? If so, describe. No.

30. Is there any infirmity of body, or limbs, any paralysis, or any striking pecularity? If so, describe fully. No.

31. Is he of average size for his age? Yes.

32. Is he active and vigorous? Does he run about and notice things, or is he indolent? Is active & vigorous—Can notice readily.

33. Is he nervous? Yes.

34. How is his appetite? Is he gluttonness? Is gluttonness.

35. What is the state of the sense of taste? Is he particular about what he eats, or will he swallow things without regard to taste? Seems to swallow without regard to taste.

36. Are sight and hearing good? Yes.

37. Is he fond of music? Yes.

38. Does he recognize color? Yes.

39. What color does he know by name? Nine.

40. Does he recognize form? No.

41. Does he notice pictures to distinguish them? No.

42. Does he understand language? To a certain extent.

43. Does he understand a command? At times.

44. Can he do errands? Sometimes.

45. Does he talk? Yes.

46. At what age did he commence to talk? √

47. Is there any peculiarity or defect of speech? If so, describe. Very little.

48. [Illegible] No.

49. [Illegible] [Illegible]

50. [Illegible] No.

51. [Illegible] No.

52. [Illegible] from 1 to 10.

53. [Illegible] Fair.

54. [Illegible] when excited wets his clothing.

55. [Illegible]

56. Can he dress and undress himself? Yes.

57. Can he bathe himself? Yes.

58. Does he use a spoon, or knife and fork? Yes.

59. Can he tie his shoestrings in a regular knot? Yes.

60. Can he do any work; and what kind? Can assist around the house.

61. Does he hide, break or destroy things? Yes.

62. Does he sleep well and quietly? No.

63. Is he obedient? No.

64. Is he passionate, or of good temper? Of good temper.

65. Has he any other unfortunate habits? Is a chronic runaway.

66. How does he amuse himself? With anything—just like a boy.

67. What cause has beeen ascribed for his mental deficiency?

68. Has he had the usual diseases of childhood—measles, scarlatina, whooping cough, etc.? Yes.

69. Has he ever been vaccinated? Yes.

70. Where was the father born? Ireland.

71. What was the general bodily condition and health of the father; was he vigorous and healthy, or the contrary? Vigorous & healthy.

72. Were all his senses perfect? Yes.

73. Was he always a temperate man? No.

74. About how old was he when the child was born?

75. If dead, at what age did the father die, and of what disorder?

76. Where was the mother of the child born? Ireland.

77. What was the general bodily condition of the mother of the child; strong and healthy, or the contrary? Strong & healthy.

78. Were all her senses perfect? Yes.

79. Was she always a temperate woman? Yes.

80. About how old was she when the child was born?

81. How many children had she before the aforesaid child was born? One.

82. How many since? Five.

83. How many have died, and of what disease? Two—No information.

84. Was there, or is there, any deformity of body, or mental deficiency in the other children? If so, describe fully. All are normal.

85. What was the state of the mother's health during the time she was pregnant with the child? Good.

86. Was she subject to any bodily injury or severe sickness, or to any extraordinary [illegible] emotion or fright, great sorrow or the like? No.

87. [Illegible] No.

88. [Illegible] About 4 yrs. died from [illegible].

[Illegible portion]

94. State fully what estate or property the child has? None.

95. State fully what estate or property the father has? None.

96. State fully what estate or property the mother has? None.

97. What is the father's residence? (?)

98. How long has he resided there?

99. From what place did he remove to his present residence?

100. What has been the father's occupation? Laborer.

101. What is the mother's residence? Deceased.

102. How long has she resided there?

103. From what place did she remove to her present residence?

104. Do the father and mother reside together?

105. Who has custody of the child?

106. What is the guardian's residence?

107. When was the guardian appointed? July 19th, 1905.

108. By what court was the guardian appointed? By Magistrate [illegible].

109. State what amount the parent or parents or legal guardian is or are able to pay? Nothing.

110. Give name and post office address of person to whom correspondence is to be directed?

(Signed) Wm. H. A. Neills
Secretary
Certificate of Magistrate or Judicial Officer
[Illegible]

CERTIFICATE OF DIRECTORS OR OVERSEERS OF THE POOR

We, the undersigned, ———— ———— of the Poor for the Poor District of Phila. Pa., hereby certify that we have examined the circumstances of the above-named child and his parents, and find that the said child has the following property and estate, to wit: none, and that his parents have the following property and estate to wit: none. And we further certify that the said child has not an estate of sufficient value to defray the expenses [illegible] of his maintenance in the Eastern Pennsylvania State Institution for the Feeble-minded and Epileptic; and that the parents of the said child are not of sufficient financial ability to defray such expense*; and that the ———— ————of the said child is — able to pay ———— dollars per month towards such expense.

And we further certify that the legal settlement of said child is in the said district.

Witness our hands the 28th day of January 1960.

(Signed) [Illegible]

[Illegible] when properly filled out to be mailed to Henry M. Weeks, M.D. Supt., Spring City, Pa.

CERTIFICATE OF PHYSICIAN

I, the undersigned, certify that I have examined the within named ———— and find that he is by reason of being feeble-minded, incapable of receiving instruction in the common schools of the state, [illegible] bodily health and no contagious disorder.

(Signed) [*Illegible*], M.D.

CAMERON, ELK, McKEAN, POTTER COUNTIES CHILD GUIDANCE CLINIC

October 30, 1971
(b. 1/23/58)

PSYCHIATRIC SUMMARY

is now a powerfully built 13 year 10 month old adolescent who has suffered from a mixed type seizure disorder and mental retardation since surviving a nearly fatal nephritis at age 4 years.

He has been on anticonvulsant medications since that age. He has also been placed on several tranquillizing drugs without notable response (Thorazine, Librium).

was first known to me when he was seen psychiatrically, in another clinic, on 5/21/70 on a school referral.

At that time, residential placement was strongly recommended, but was not carried out.

However, such placement should in no way, be delayed in present circumstances which are marked by very sudden, explosive, rage reactions in which he attacks others and for which he has no recollection.

In one instance this summer, while at camp, it took five persons to restrain .

One of the five, a counsellor, lost several teeth in the process.

On several instances, he has physically attacked his mother who, on one occasion, was saved when a neighbor called dad who, with 17 year old brother, have been able to restrain during his wild rages only because of their combined strength.

In view of the foregoing, it is most urgently recommended that be placed in the Polk State School for the protection of , himself, and of others who might become victims of his unforseeable, sudden episodes of violence.

John T. Pitkin, M.D.
John T. Pitkin
Psychiatric Consultant
Confidential
For Professional Use Only
13 173

CAMERON, ELK, McKEAN, POTTER COUNTIES
MH/MR CLINIC

133-135 North Bennett Street,
Bradford, Pennsylvania 1670

September 15, 1971

PSYCHOLOGICAL EVALUATION

Name: is a 13-7 year old white single male residing with his parents at . He had "nepheritis" at age 4. He receives home tutoring.

Reason for Testing: Parents wish to process papers for Polk State School and Hospital.

Date Tested: September 15, 1971

Instruments Used: Wechsler Intelligence Scale for Children
Wide Range Achievement Test
Bender Gestalt
Vineland Social Maturity Scale

Observations:

related well to the examiner. He was courteous and displayed some social amenities. His physical movements were slow, while no gross physical handicaps were noted. His speech was slow, but was clear and distinct. He understood instructions well and seemed to enjoy the various test items.

Results:

Scaled Scores		*Scaled Scores*	
Information	6	Picture Completion	4
Comprehension	4	Picture Arrangement	2
Arithmetic	6	Block Design	2
Similarities	4	Object Assembly	0
Vocabulary	0	Coding	0

Verbal I.Q. 62
Performance I.Q. 44
Full Scale I.Q. 48

is functioning in the Moderate Range of Mental Retardation. It is to be noted that his verbal functioning is at a higher level. While he has difficulties with abstraction and creativity, he can remember factual material and reason in a concrete manner. His visual figure-ground perceptions indicate organicity. His scores in the Performance tasks were depressed by his slow motor activity.

Wide Range Achievement Test

Reading Level 3.6
Arithmetic Level 4.2

Results from psychologicals done in 1966 indicated reading at 1.3 and arithmetic 1.8. It seems that has been able to benefit from his home tutoring.

Vineland Social Maturity Scale, with his mother as informant, estimated a social age around 9.0. He does well with self-help skills, but lags behind in socialization and any remunerative or creative tasks.

David Lee
Confidential
For Professional Use Only
13 173

CREDIT REPORT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF REVENUE
BUREAU OF INSTITUTIONAL CORRECTIONS

Date: 12/20/71

Institution: Polk State School & Hospital
Patient's Name:
Legal Residence:
Street & Number:
City or Town:
County & State: McKean County, Pa.
Patient's Number: 13,173
Birth Date: 1/23/58
Veteran Yes ☐, No ☐; Vet. Serial No.
Dependent of Vet. Yes ☐, No. ☐; Vet. Claim No.
Admission Date: 12/20/71
Soc. Sec. No.: RA will apply
Medicare: Plan "A" ☐ Plan "B" ☐ Number of days previously used under Plan "A":

Marital Status: Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Number of Children:
Wife or Husband's Name & Address:
Patient's Parents:
Name: Father: ; Street No.: ; Address: ; City and State: ; Social Security No.: 208-20-5908; Deceased Date:
Name: Mother: ; Street No.: ; Address: ; City and State: ; Social Security No: 188-22-9341; Deceased Date:
Legally Liable: Spouse ☐ Parent ☒ Child ☐ Guardian ☐ Trustee ☐ Committee ☐
Name: ; Street and Number: same as above; City and State:
Legally Liable's Employers Name and Address: ; Weekly Salary:
Insurance: (1) Patient's ☐ (2) Parent's ☐ (Check)
Insurance Company Name: ; Address: ; Health: ; Life: ; Other: ; Amount:
Real Estate: (1) Patient's ☐ (2) Spouse's ☐ (3) Parent's ☐ (4) Son's or Daughter's ☐
Type: ; Address: ; Owner's Name: ; Value:
Personal Property: Stocks ☐ Bonds ☐ Savings and Checking Account ☐ Mortgages ☐ Other ☐ (Explain):

Signatures:
Person Interviewed: ; Relationship: mother & Father; Date: 12/20/71; Interviewer and Date: Charles R. Bruner, Revenue Agent

A. Eligibility: ; Classified: Part Pay; Date: 12/20/71; Revenue Agent: [Illegible]

13 173

Street City

Other Remarks: (Any information that was not shown on the reverse side because of space limitations, may be shown in this section.)

Send all correspondence to:

Father signed Part Pay agreement 12/20/71 for $17.00.

13 173

Nov. 26, 1971

APPLICATION FOR ADMISSION TO A MENTAL HEALTH OR MENTAL RETARDATION FACILITY

Mental Health and Mental Retardation Act of 1966
(Sections 402, 403, 404 and 405)

Type of Admission

☒ Voluntary Admission (Complete Parts I and III)

☐ Voluntary Commitment (Complete Parts I and IV)

☐ Emergency Detention (Complete Parts I, V and VI)

☐ Medical Certification (Complete Parts I, II, VI and VII, if patient is mentally retarded also complete Part VIII)

To Be Completed by Facility

Name of Facility: POLK STATE SCHOOL AND HOSPITAL

Admission Date: Decenber 20, 1971

Case Number: 13,173

PART I. PERSONAL DATA

Patient's Name (Last, First, Middle):

Maiden Name:

Aliases:

Social Security No.:

Address (Street, Town, State): Pa.

Sex: ☒ Male; ☐ Female

Age on Admission: 13

Date of Birth: Month: 1; Day: 23; Year: 1958

Education: (Enter highest grade completed inc. college & advanced study):

Marital Status: ☐Married; ☐ Widowed; ☐ Divorced; ☐ Separated; ☒ Never Married

Occupation: None

Income (Total gross annual family income to nearest thousand dollars): $——

Number of Persons Dependent on Income:

Previous Psychiatric Service:

☒ None

☐ Pa. State Mental Hosp. (24 hr. care)

☐ Private Mental Hospital

☐ VA Hospital

☐ Pa. State Mental Retardation Facility

☐ Psychiatric Unit General Hosp.

☐ Other Inpatient Care

☐ Psychiatric Day-Night Care

☐ Private Mental Retardation Facility

☐ Private Psychiatrist

☐ Outpatient Clinic

☐ Other Outpatient

If patient recently received treatment from an above noted facility and/or physician, please enter name(s):

Name, Address and Relationship of Responsible Relative:

Telephone No.:

Date: 11-23-71

_____

Signature of Applicant

PART II.

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths.

(Only Required for Medical Certification Admission)

State of _____)
) ss
County of _____)

_____ being duly sworn/affirmed according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Sworn/affirmed to and subscribed before me this — day of _____ A.D. 19—.

_____

(Signature of Applicant)

I certify that the signature to the foregoing petition is genuine.

_____

Signature of Person Administering Oath

13 173

PART III.

APPLICATION FOR VOLUNTARY ADMISSION
(Under provisions of Section 402)

_____

(Patient's Name)

I hereby make application for voluntary admission to Polk State School and Hospital for ☐ myself ☒ above named patient. I understand that I may leave the facility at any time or may remove the above minor patient from the facility at any time.

_____

Signature of patient or applicant

11-23-71
Date

Father
If not patient—relationship to patient

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parents, or guardian, or other person in loco parentis.

13 173

13173

12,560

McKEAN COUNTY

Admitted 12-20-71

Filed: 11/16/71
Accepted: 11/16/71
For Admission: 12/20/71

POLK STATE SCHOOL AND HOSPITAL

I-21

PSYCHOLOGICAL EXAMINATION

Name: ; Birthdate: 1/23/53; No. 13,173

Admitted: 12/20/71; Examined: 12/30/71; Psychologist: H. W. Lamb

Practical Knowledge: Fair

Psychometrics:

Date: 12/30/71; Kind: SIT; CA: 13-11; MA or SA: 9-2; IQ or SQ: 66; Status & Degree of Retardation: ; Code

Date: 12/30/71; Kind: Raven; CA 13-11; MA or SA: 10-9; IQ or SQ: 77; Status & Degree of Retardation: Mild; Code

Date: 12/30/71; Kind: WRAT: Reading 4.4; Arithmetic 3.9

Date: 12/30/71; Kind: Bender-Gestalt: PMA 8-0

Projectives:

Date: 12/30/71; Kind: Rorschach; Qualifying Personality Reaction: ; Code

Date: 12/30/71; Kind: Hand Test; Qualifying Personality Reaction: without qualifying phrase; Code

PSYCHOLOGICAL IMPRESSIONS

——— is a convulsive young man 13-11, who is dangerously assaultive and it is not clear to what extent his behavior reflects his moods, possible psychomotor seizures, or bullying. He also uses drugs to control seizures. His outbreaks appear to be cyclical and he seems to exhibit more than normal STrength during their course. The Hand Test showed a marked dependency and a possible passive-aggressive orientation, but control appeared adequate and there were no signs of significant pathology.

The Bender-Gestalt Test showed a perceptual-motor age level below his mental level ascertained on intelligence tests, and there were some 'irritable' dots and indications of poor fine control consistent with a convulsive history.

The Rorschach was very unusual and not at all characteristic of mental retardation but contained many confabulations, human movement, contaminations and dysphoric content. The extent to which contaminations and confabulations reflect a psychotic process or simply mental retardation is debatable, but there is a definite aura of schizo-affective tone.

——— behavior is a more serious obstacle to his return to the community than his retardation. He has a combative posture that is easily set off by cyclical tensions paralleling his confabulatory processes and these may trigger psychomotor-like attacks.

13 173

CREDIT REPORT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF REVENUE
BUREAU OF INSTITUTIONAL COLLECTIONS

Date: November 18, 1970

Institution: Polk State School

1. Patient's Name:

Legal Residence:

Street & Number:

City or Town:

County & State: Lawrence County, Pa.

Patient's Number: #13,077

Birth Date: 12/13/56

Veteran: Yes ☐, No ☐; Vet. Serial No.

Dependent of Vet.: Yes ☐, No ☐; Vet. Claim No.

Admission Date: 11/17/70

Soc. Sec. No.

Medicare: Plan "A" ☐ Plan "B" ☐ Number of days previously used under Plan "A"

Marital Status: Single ☒ Married ☐ Separated ☐ Divorced☐ Widowed ☐ Number of Children:

Wife or Husband's Name & Address:

2. Patient's Parents:

Name: Father: ; Street No.: last address; Address: ; City and State: ; Social Security No.: ; Deceased Date:

Name: Mother: ; Street No.: ; Address: ; City and State: ; Social Security No.: ; Deceased Date:

3. Legally Liable: Spouse ☐ Parent ☒ Child ☐ Guardian ☐ Trustee ☐ Committee ☐

Name: ; Street and Number: As above; City and State:

Name: ; Street and Number: As above; City and State:

Legally Liable's Employers Name and Address: ; Weekly Salary:

4. Insurance: (1) Patient's ☐ (2) Parent's ☐ (Check)

Insurance Company Name: ; Address: Health: ; Life: ; Other: ; Amount:

Real Estate: (1) Patient's ☐ (2) Spouse's ☐ (3) Parent's ☐ (4) Son's or Daughter's ☐

Type: ; Address: ; Owner's Name: ; Value:

Personal Property: Stocks ☐ Bonds ☐ Savings and Checking Account ☐ Mortgages ☐ Other ☐ (Explain):

Signatures:

Person Interviewed: ; Relationship: Mother; Date: 11/17/70; Interviewer and Date:

A. Eligibility: ; Classified: Indigent; Date: ; Revenue Agent:

13 077

Name Street City

Born: 9/11/52 Married
10/31/54
12/ 5/59
10/16/65
3/ 6/68

Other Remarks: (Any information that was not shown on the reverse side because of space limitations, may be shown in this section.)

Send all correspondence to:

Also: Mr. Darrell Black, Caseworker

Tenantment Relations Office Housing Authority
Lawrence County
New Castle, Pa.

13 173

APPLICATION FOR ADMISSION TO A MENTAL HEALTH OR MENTAL RETARDATION FACILITY

Mental Health and Mental Retardation Act of 1966
(Sections 402, 403, 404 and 405)

Type of Admission

☐ Voluntary Admission (Complete Parts I and III)

☐ Voluntary Commitment (Complete Parts I and IV)

☐ Emergency Detention (Complete Parts I, V and VI)

☒ Medical Certification (Complete Parts I, II, VI and VII, if patient is mentally retarded also complete Part VIII)

To Be Completed by Facility

Name of Facility: POLK STATE SCHOOL AND HOSPITAL

Admission Date: Nov. 17, 1970

Case Number: 13,077

PART I. PERSONAL DATA

Patient's Name (Last, First, Middle):

Maiden Name:

Aliases:

Social Security No.:

Address (Street, Town, State): 16101

Sex: ☒ Male; ☐ Female

Age on Admission: 14

Date of Birth: Month: 12; Day: 13; Year: 56

Education: (Enter highest grade completed inc. college & advanced study): Special Ed.

Marital Status: ☐ Married; ☐ Widowed; ☐ Divorced; ☐ Separated; ☒ Never Married

Occupation: N.A.

Income (Total gross annual family income to nearest thousand dollars): Active Public Assistance

Number of Persons Dependent on Income: N.A.

Previous Psychiatric Service:

☐ None
☐ Pa. State Mental Hosp. (24 hr. care)
☐ Private Mental Hospital
☐ VA Hospital
☐ Pa. State Mental Retardation Facility
☐ Psychiatric Unit General Hosp.
☐ Other Inpatient Care
☐ Psychiatric Day-Night Care
☐ Private Mental Retardation Facility
☐ Private Psychiatrist
☒ Outpatient Clinic √
☐ Other Outpatient

If patient recently received treatment from an above noted facility and/or physician, please enter name(s):

Name, Address and Relationship of Responsible Relative: Mother

Telephone No.:

Date: October 27, 1970

Signature of Applicant

PART II.

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths.

(Only Required for Medical Certification Admission)

State of Pennsylvania)
) ss
County of [Illegible])

_____ being duly sworn/affirmed according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Sworn/affirmed to and subscribed before me this 27th day of October A.D. 1970.

_____
(Signature of Applicant)
Mrs. Shirley Belknap Kerr
Signature of Person Administering Oath
Notary Public
Union Township,
Lawrence County
My Commission Expires Oct. 10, 1974

Commonwealth of Pennsylvania
Department of Public Welfare
MH, MR-1-6/69

PART III.

NA

APPLICATION FOR VOLUNTARY ADMISSION
(Under provisions of Section 402)

_____
(Patient's Name)

I hereby make application for voluntary admission to

_____
(Name of Facility)

for ☐ myself ☐ above named patient. I understand that I may leave the facility at any time or may remove the above minor patient from the facility at any time.

_____
Signature of patient or applicant

_____
Date

_____
If not patient—relationship to patient

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parents, or guardian, or other person in loco parentis.

PART IV.

NA

APPLICATION FOR VOLUNTARY COMMITMENT
(Under provisions of Section 403)

_____
(Patient's Name)

I hereby make application for voluntary commitment to _____ for ☐ myself
(Name of Facility)
☐ above named patient. I understand that I must give at least ten (10) days notice in writing to the director if I desire to leave the facility or remove the above named minor patient from facility.

_____
Signature of patient or applicant

_____
Date

_____
If not patient—relationship to patient

Witness

Address of Witness

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parent, or guardian, or other person in loco parentis.

(This commitment is not to exceed 30 days)

PART V.

NA

APPLICATION FOR COMMITMENT FOR EMERGENCY DETENTION
(Under provisions of Section 405)

Application for emergency detention of the patient is hereby made to:

Administrator _____ County

I believe that _____ is mentally
(Name of Patient)
disabled and that immediate emergency detention is necessary.

State your reasons for believing that the patient is mentally disabled (Include the acts or threats which give you reason to believe emergency detention is necessary.):

(Signature of Applicant)

Date

APPROVAL FOR TAKING INDIVIDUAL INTO CUSTODY AND DISPOSITION

(Name of Patient)

☐ Shall be examined by _____
(Name of Physician)
and if required admitted to _____
(Name of Facility)

☐ Shall be admitted direct to _____
(Name of Facility)
for a period not to exceed ten (10) days.

(Signature of Administrator or Delegate)

Date

NOTE: Upon receipt of the approved application and certificate the Director may receive and detain the patient for emergency detention for a period not to exceed ten (10) days.

CERTIFICATE OF PHYSICIAN

[Illegible]

IF PATIENT IS MENTALLY ILL—Admission MUST be made within thirty (30) days of the first certifying examination.

IF PATIENT IS MENTALLY RETARDED—Admission MUST be made within three (3) months of first certifying examination.

FOR EMERGENCY DETENTION — Admission MUST be made immediately after certifying examination.

Name of Patient:

Birth: 12-13-56
Date of Examination: 10-30-70
Address of Patient:

HISTORY OF ILLNESS AS GIVEN BY APPLICANT AND OTHER RELEVANT INFORMATION INCLUDING REPORT OF PSYCHOLOGIST IF PATIENT IS MENTALLY RETARDED

(Form is attached for Report of Psychologist)

Been taken care of by Childrens Hospital in Pittsburgh, Pa since 8 Months old.

I.Q. of 34.—Mental retardation

1967: Surgical [Illegible]

Physical and Mental Findings at Time of Examination:

Physical Complaint: pain in lower walls of [Illegible]

Obesity: 181 lbs.

[Illegible] of legs

Poor coordination of legs—[Illegible] Reflexes knee.

Retarded—childish in response

I certify that I am licensed to practice medicine or osteopathy in Pennsylvania and that I have examined the patient with care and diligence within one week prior to the date of this certification.

In my opinion the patient is:

☐ Mentally Ill
☒ Mentally Retarded
☐ Not Mentally Disabled

(REQUIRED ONLY FOR EMERGENCY DETENTION UNDER SECTION 405)

☐ Patient in Need of Emergency Detention

☐ Patient Not in Need of Emergency Detention

G. S. Cunningham, M.D.
Signature of Physician
16101
Address of Physician

Date: 10-30-70

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths
(Only Required for Medical Certification Admission)

State of Pennsylvania)
) ss
County of Lawrence)

G. S. Cunningham being duly sworn according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

G. S. Cunningham
(Signature of Physician)

Sworn/affirmed to and subscribed before me this 10 day of Nov. A.D. 1970.

I certify that the signature to the foregoing petition is genuine.

Howard B. Hanna,
Signature of Person Administering Oath
Notary Public
[Illegible]
[Illegible]

CERTIFICATE OF PHYSICIAN

IF PATIENT IS MENTALLY ILL—Admission MUST be made within thirty (30) days of the first certifying examination.

IF PATIENT IS MENTALLY RETARDED—Admission MUST be made within three (3) months of first certifying examination.

Name of Patient:
Date of Examination: 10/31/70
Address of Patient: Pa.

HISTORY OF ILLNESS AS GIVEN BY APPLICANT AND OTHER RELEVANT INFORMATION INCLUDING REPORT OF PSYCHOLOGIST IF PATIENT IS MENTALLY RETARDED

(Form is attached for Report of Psychologist)

[Illegible]: I.Q.—34.
History: birth trauma
Physical and Mental Findings at Time of Examination:
Retarded

[Illegible] normal except for obesity—has definite hernia—secondary sex characteristics beginning

I certify that I am licensed to practice medicine or osteopathy in Pennsylvania and that I have examined the patient with care and diligence within one week prior to the date of this certification.

In my opinion the patient is:
☐ Mentally Ill
☒ Mentally Retarded

☐ Not Mentally Disabled

Theodore A. Gravel, Jr., M.D.
Signature of Physician
New Castle, Pa.
Address of Physician
[Illegible]
New Castle, Pa. 16101

Date: 10/31/70

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths

(Only Required for Medical Certification Admission)

State of Pennsylvania)
) ss
County of Lawrence)

Theodore A. Gravel being duly sworn according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Theodore A. Gravel, Jr.
(Signature of Physician)

Sworn to and subscribed before me this 10 day of Nov. A.D. 1970.

I certify that the signature to the foregoing petition is genuine.

Howard B. Hanna
Signature of person administering Oath

REPORT OF PSYCHOLOGIST

Patient's Name:
Birthdate: 12/13/56
Date of Examination: 12/23/69

BACKGROUND INFORMATION

MATURATION (Significant lag in growth and development): was a short, obese, 13 year old boy, with an appearance of retardation. He wore glasses and has obvious tongue thrust. He cooperated well until his tasks became more difficult, then he became angry and petulant. His speech was extremely limited, appearing to have a difficult time thinking of names of objects. He frequently made motions to designate the use of the object, or he emitted sounds related to the objects pictured.

——— ——— ☐ over

SOCIAL ADJUSTMENT: ———, a severely retarded boy, at the present time is living with his grandparents. He seems to have been manageable in his mother's home up until a year ago. However, this was accomplished by her occasionally farming her other children to relatives. Mother shows considerable immaturity and inadequacy in handling children; therefore, she was quite uncapable of handling [Illegible].

He attended special education classes in New Castle. This training does not seem to have altered his behavior sufficiently so that he could be maintained at home. The patient's basic problem is one of retardation. In the last year, however, he has begun to "act out" aggressively and is becoming interested in "sex". ☐ over

NAMES OF TESTS AND RESULTS: Stanford-Binet Intelligence Scale Form L-M—earned a mentally 3½ years. For his chronological age of 13, the IQ earned was

34. The range of testing extended from the 3-year level where he passed all of the test items to the 4½-year level where he failed the test items. (NO Tests attempted at higher levels because of his angry response to the pressure of more difficult tasks. It's possible that he could have passed some additional test items.

DIAGNOSIS (AAMD Classification): ———

——— was a severely retarded boy, 13, IQ 34, mental age 3½ years. He was particularly inept in language expression & appeared to have a greater understanding than he was able to communicate verbally. Responded to pressure with infantile anger. Although it was impossible to give him extensive personality testing, he indicated considerable hostility which he has been reported to have released in fire setting & attacks on other children. Emotional control & confused orientation are undoubtedly more of a threat in the home where he experiences more rivalry & opportunity to perform. Placement in a residential (over) DIAGNOSIS, Cont.—center for the severely retarded should be arranged as soon as possible.

Virginia Fulcomer, Ph.D
Clinical Psychologist

Record the Person's Level of Development for Each of the Following:

1. Attribute: Self-Help Skills: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .
2. Attribute: Attentional Development: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .
3. Attribute: Perceptual Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

4. Attribute: Psychomotor Functioning: Severely Sub-Average: ; Moderately Sub-Average: ; Mildly Sub-Average: x; Average: ; Above Average: .

5. Attribute: Communication Skills: Severely Sub-Average: ; Moderately Sub-Average: ; Mildly Sub-Average: x; Average: ; Above Average: .

6. Attribute: Concrete Cognitive Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

7. Attribute: Abstract Cognitive Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

8. Attribute: Vocational Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

9. Attribute: Personality Integration: Severely Sub-Average: x; Moderately Sub-Average: ; Mildly Sub-Average: ; Average: ; Above Average: . □ over

Virginia Fulcomer, PhD. Clinical Psych.
Psychologist
Mental Health Clinic of Lawrence County

Prepared by:
Louis F. Palumbo
Social Services Director
Lawrence County Housing Authority

LAWRENCE COUNTY
Admitted 11-17-70

Filed: 6/20/69
Accepted: 10/13/70
For Admission: 11/17/70

13077

W.S.S.H.

00015

Reason for placement:

"If ———————— remains for any length of time in this home, I think there is a very good chance of mother breaking down, the marriage ending in separation, father's health failing and the adolescent daughter being pushed into a premature marriage to escape an unhappy home."

Diagnosis (July 20, 1960):

Mental Status: Severe-Idiot I.Q.—10

Diagnosis: Mental deficiency with congenital cerebral spastic paralyses

Cause: Congenital cerebral defect

Somatic diseases: Spastic quadriplegia; Cleft soft palate; Microcephaly; Dental caries

Body condition on admission: Impaired

Behavior disorders: None

00067

Reason for placement:

"Since maternal grandparents have come to live with the family, this has presented serious problems. The maternal grandmother needs constant care but the maternal grandfather has been unable to help and acts as if he hates everyone. The older sister, ————————————, has also had problems in adjusting to the situation. Mother was said to be close to a nervous breakdown and could no longer cope with both ———————— and the maternal grandmother."

Diagnosis (October 1, 1963):

AAMD

Mental Retardation associated with Encephalopathy due to anoxemia at birth

Visual handicap

Hearing handicap

Major motor seizures

Choreoathetosis

Spastic quadriplegic

APA

Chronic Brain Syndrome associated with birth trauma (anoxemia due to cord being wrapped around neck)

Mental deficiency (x^4)—Severe

OO131

Reason for placement:

"It was the worker's impression that this boy was in need of placement because now he has become uncontrollable. The parents realized that at their age they will have increasing difficulty in coping with their son."

W.S.S.H.

00131 (cont'd.)

Diagnosis (December 5, 1963):

AAMD

Mental Retardation associated with mongolism

Level II—Adaptive Behavior—Trainable (?)

APA

Chronic Brain Syndrome associated with pre-natal influence, mongolism, without qualifying phrase

Mental deficiency (x^4)—Severe

00144

Reason for placement:

"The father described her as hyperactive, but the mother disagreed and said that she was only active. Though the parents stated that she was well accepted at home, they felt that now that she is entering pubescence, it will be better for her to be admitted at this time. The maternal aunt who had been caring for her was away and since she was the one against placement, the parents felt that this was the time to arrange for placement. The brothers, though they love ————, are uncomfortable in her presence."

Diagnosis (December 27, 1963):

AAMD

Mental retardation associated with encephalopathy due to anoxemia at birth

Spastic paraplegia

Level II—Adaptive Behavior—Trainable

APA

Chronic Brain Syndrome due to unkown cause without qualifying phrase

Mental deficiency (x^4)—Severe

Re-evaluated diagnosis (March 18, 1974):

AAMD

Trauma or physical agent-perinatal hypoxia

Hydrocephalus, secondary

Spasticity with paraplegia, moderate

Adaptive Behavior-Level III (1973 Revised Classification)

00281

Reason for placement:

". . . she had become a management problem to both her parents and the community."

Diagnosis (August 26, 1964):

AAMD

Mental Retardation due to uncertain cause with the functional reaction alone manifest

Major motor seizures (history)

Level III—Adaptive Behavior

W.S.S.H.

00281 (cont'd.)

Diagnosis (cont'd.):

APA

Mental deficiency, idiopathic, severe bordering on moderate

00288

Reason for placement:

Poor family situation—mother does not get along with patient well. The family is ". . . afraid that the mother would have another nervous breakdown if it (placement) was not done soon."

Diagnosis (September 2, 1964):

AAMD

Mental retardation, cause unknown, with the structural reaction manifest

Hearing and visual handicap

Tremor-head

Level II—Adaptive Behavior—Trainable child

APA

Chronic Brain Syndrome due to unknown cause

Mental deficiency (x^4)—Severe

PSYCHOLOGICAL REPORT

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Name:

Date of Testing: 7/11/72

Date of Birth: 9/20/61

Chronological Age: 10 years, 10 months

Referred by: The patient's parents

Reason for Referral: Interim short term placement at Polk State School and Hospital during the family's vacation.

Tests Administered: Wechsler Intelligence Scale for Children and the Draw-a-Person Test

Test Behavior:

was extremely cooperative and friendly throughout the complete testing session. He brought his Raggedy Ann doll along with him and related to this doll as if it were possessing human capabilities. , or as he is called , calls this doll Raggy and several times throughout the session asked Raggy if she were comfortable or if she knew what the test answers were. is an affectionate child who goes out of his way to express positive affection and his liking for people. One cannot help but return this affection to him.

WISC:

On this scale achieved a full scale IQ of 54, a verbal 10 of 52 and a performance IQ of 64 which places him in the Mental Defective range of intellectual functioning. The verbal tests ranged in scale score from 0 through 4 with the low scale score of 0 being found on the Comprehension and Similarities subtests. As such, has

extremely defective abilities relating to the ability to evaluate past experiences and to abstract and generalize. The scale score of 4 was found on the [illegible].

13 212

—2—

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The performance tests ranged in scaled scores from 4 through 7 with the low scaled score of 4 being found on Picture Arrangement, Block Design and Coding. The high scaled score of 7 was found on Picture Completion which suggests very high, at least high for this individual, ability relating to visual recognition and differentiation. Even though this child has low intellectual abilities he seems to have developed well within his excellent social and family environment and it can be anticipated that he will develop in the future along these similar lines.

Draw-a-Person Test:

Since indicated a desire to draw he was provided with paper and asked to draw a picture of a person. immediately indicated that he wanted to draw Raggy and proceeded to do such. His difficulty developed in the drawing of legs and he wanted this examiner to draw them for him. When the responsibility was placed upon him he made an attempt and his drawing seems to be at least recognizable of human form. Using the Goodenough Scoring System it was found that has a mental age of 7 years, 3 months which computes into an IQ of 67. This IQ seems to be consistent with the results found from the WISC.

In Summary:

is a child almost of 11 years who has intellectual abilities of a Mental Defective nature. Verbal abilities seem to be low although they do point towards some development and the performance abilities seem to be of a higher nature. During the testing session it was noticed that does have a fairly extensive vocabulary and he is able to combine words into moderate length sentences. Since there is a lack of community facilities which can provide emergency placement it is being recommended that this child be placed at Polk State School and Hospital for a period of 1 to 2 weeks so that the other family members can go on a family vacation. Considering the future it is this examiner's —3— opinion that will be able to continue in the special education programs in the public schools up until the age of 21 and that sheltered workshop placement can be considered from that point on.
should be offered the opportunity for family counseling so that they can provide the best possible educational and vocational experiences for their son.

T. W. Morris
TWM
Coordinator of Mental Retardation Services

TWM:pr

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[Illegible]

Institution: Polk State School and Hospital
Patient's Name:
Legal Residence:
Street & Number:
City or Town:
County & State: Crawford, Penna.
Patient's Number: #13,212

Birth Date: 9/20/61
Veteran: Yes ☐, No ☐; Vet. Serial No.
Dependent of Vet.: Yes ☐, No ☐; Vet. Claim No.
Admission Date: 7/20/72
Soc. Sec. No.:
Medicare: Plan "A" ☐ Plan "B" ☐ Number of days previously used under Plan "A":
Marital Status: Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Number of Children:
Wife or Husband's Name & Address:
Patient's Parents:
Name: Father: ; Street No.: ; Address: ; City and State: ; Social Security No.: 207-22-3626; Deceased Date:
Name: Mother: ; Street No.: ; Address: ; City and State: ; Social Security No.: ; Deceased Date:
Legally Liable: Spouse ☐ Parent ☒ Child ☐ Guardian ☐ Trustee ☐ Committee ☐
Name: ; Street and Number: ; City and State:
Legally Liable's Employers Name and Address: ; Monthly Salary: $685.00
Insurance: (1) Patient's ☐ (2) Parent's ☐ (Check)
Insurance Company Name: ; Address: ; Health: ; Life: ; Other: ; Amount:
Real Estate: (1) Patient's ☐ (2) Spouse's ☐ (3) Parent's ☒ (4) Son's or Daughter's ☐
Type: Frame (5 rm.); Address: ;

Owner's Name: ; Value: $19,500.00
Personal Property: Stocks ☒ Bonds ☐ Savings and Checking Account ☒ Mortgages ☒ Other ☐ (Explain):
Stocks:
Mortgage:
Signatures:
Person Interviewed: ; Relationship: Parents; Date: 7/20/72; Interviewer and Date: Anita Ghering—7/20/72
A. Eligibility: ; Classified: Part Pay; Date: 7/20/72; Revenue Agent: [Illegible]
Born: 12/16/65
Other Remarks: (Any information that was not shown on the reverse side because of space limitations, may be shown in this section.)
Patient was brought to Polk from home in and was accompanied by both parents.
Telephone number of parents:
Correspondence to be sent to:

APPLICATION FOR ADMISSION TO A MENTAL HEALTH OR MENTAL RETARDATION FACILITY
Mental Health and Mental Retardation Act of 1966
(Sections 402, 403, 404 and 405)

Type of Admission

☒ Voluntary Admission (Complete Parts I and III)
☐ Voluntary Commitment (Complete Parts I and IV)
☐ Emergency Detention (Complete Parts I, V and VI)
☐ Medical Certification (Complete Parts I, II, VI and VII. If patient is mentally retarded also complete Part VIII)

To Be Completed by Facility

Name of Facility: POLK STATE SCHOOL AND HOSPITAL

Admission Date: July 20, 1972
Case Number: 13,212

PART I. PERSONAL DATA

Patient's Name (Last, First, Middle):
Maiden Name:
Aliases:
Social Security No.:
Address (Street, Town, State):
Sex: ☒ Male; ☐ Female
Age on Admission: 10
Date of Birth: Month: 9; Day: 20; Year: 61
Education: (Enter highest grade completed inc. college & advanced study):
Marital Status: ☐ Married; ☐ Widowed; ☐ Divorced; ☐ Separated; ☐ Never Married
Occupation:
Income (Total gross annual family income to nearest thousand dollars):
Number of Persons Dependent on Income:
Previous Psychiatric Service:

- ☐ None
- ☐ Pa. State Mental Hosp. (24 hr. care)
- ☐ Private Mental Hospital
- ☐ VA Hospital
- ☐ Pa. State Mental Retardation Facility
- ☐ Psychiatric Unit General Hosp.
- ☐ Other Inpatient Care
- ☐ Psychiatric Day-Night Care
- ☐ Private Mental Retardation Facility

- ☐ Private Psychiatrist
- ☐ Outpatient Clinic
- ☐ Other Outpatient

If patient recently received treatment from an above noted facility and/or physician, please enter name(s):

_____

Name, Address and Relationship of Responsible Relative: [Illegible]
Telephone No.: [Illegible]

_____
Signature of Applicant

Date: July [Illegible]

PART II.

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oath.

(Only Required for Medical Certification Admission)

State of _____)
) ss
County of _____)

_____ being duly sworn/affirmed according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Sworn/affirmed to and subscribed before me this — day of _____ A.D. 19—.

_____
(Signature of Applicant)

I certify that the signature to the foregoing petition is genuine.

_____
Signature of Person Administering Oath

Commonwealth of Pennsylvania
Department of Public Welfare
MH/MR-1-10/70

PART III.

APPLICATION FOR VOLUNTARY ADMISSION
(Under provisions of Section 402)

(Patient's Name)

I hereby make application for voluntary admission to Polk State Mental Hospital for ☐ myself ☒ above named patient. I understand that I may leave the facility at any time or may remove the above minor patient from the facility at any time.

Signature of Patient or Applicant

Date: July [Illegible]

Mother
If not patient—relationship to patient

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parents, or guardian, or other person in loco parentis.

CRAWFORD COUNTY

Admitted 7/20/72

Filed: 7/17/72
Accepted: 7/17/72
For Admission: 7/20/72

POLK STATE SCHOOL AND HOSPITAL

I-21

PSYCHOLOGICAL EXAMINATION

Name: ; Birthdate: 9/20/61; No. 13,212

Admitted: 7/20/72; Examined: 7/26/72; Psychologist: H. W. Lamb

Practical Knowledge: Poor

Psychometrics:

Date: 7/26/72; Kind: SIT; CA: 10-10; MA or SA: 5-9; IQ or SQ: 53; Status & Degree of Retardation: ; Code

Date: 7/26/72; Kind: Raven; CA: 10-10; MA or SA: 5-9; IQ or SQ: 53; Status & Degree of Retardation: Mild; Code

Projectives:

Date: ; Kind: ; Qualifying Personality Reaction: without qualifying phrase; Code

PSYCHOLOGICAL IMPRESSIONS

——————— is an educable mongolian boy who should be placed in an educable rather than a trainable program. He is more active than the typical mongolian physically and more alert mentally. He was seen at the Outpatient Clinic by Joseph O'Mara in January, 1966; and at that time he had a social quotient of 60 and was ruling the roost at home. While autonomy for mongolians is questionable, has the capacity to participate in many educable and trainable activities, and an active program appropriate for his active state could keep him functioning at a higher level than is usual for mongolians and might minimize the stigmata and physical characteristics typical of mongolism.

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

No. 72-2272 Civil Action

Kevin Bartley, et al.,
Plaintiffs

v.

Jack B. Kremens, et al.,
Defendants

Philadelphia, Pennsylvania
July 31, 1974

PRETRIAL ORAL EXAMINATION OF DR. MAX SUGAR

---

(1) Pretrial oral examination of Dr. Max Sugar, a witness, taken on behalf of the defendants, pursuant to Notice, at 1300 State Office Building, Philadelphia, Penna., on Wednesday, July 31, 1974, commencing on or about 9:33 o'clock A.M., before Marvin Dinter, Official Court Reporter.

Present:

David Ferleger, Esq., Attorney for Plaintiffs.

Barry A. Roth, Esq., Assistant Attorney General, Attorney for Defendants.

Also Present:

Ron Hartman, Law Clerk.

(2) DR. MAX SUGAR, being first duly sworn, was examined and testified as follows:

THE COURT REPORTER: Dr. Sugar, would you please state your full name and address, for the record.

THE WITNESS: Dr. Max Sugar. My address is 3625 Chestnut Street, New Orleans, Louisiana, 70115.

BY MR. ROTH:

Q. What is your profession, please?

A. I am a psychiatrist.

Q. And where did you receive your training?

A. I went to Medical School at the University of Toronto where I got my degree in Medicine and an internship in New Orleans, and I had my residency training in psychiatry and child psychiatry in New Orleans at Louisiana State University and at Tulane University and in New Orleans Child Guidance Clinic.

Q. Are you Board Certified?

A. Board Certified in General Psychiatry and in Child Psychiatry.

Q. Have you written any articles or books?

A. Yes. I have written about 35 articles and I am currently (3) editing a book which will be published this year.

Q. Do some of the articles pertain to child psychiatry?

A. Yes.

Q. Do you have any speciality within the field of psychiatry?

A. Yes, I am a Child Psychiatrist. I also have a special interest in adolescent psychiatry. I have been very

active with the American Society for Adolescent Psychiatry, and I am the immediate past president thereof.

Q. How long have you been practicing?

A. Well, I have been a physician since 1948, 26 years.

Q. And could you indicate what your current position is.

A. I am Clinic Professor of Psychiatry at Louisiana State University in New Orleans, and I am in private practice in New Orleans.

(Whereupon, Mr. Ferleger entered the deposition room.)

MR. FERLEGER: Would you please read back the questions and answers for me, please.

(Whereupon, the preceding questions and answers were read back by the court reporter.)

BY MR. ROTH:

Q. Dr. Sugar, have you been appraised of the two sections of the Pennsylvania Mental Health and Mental Retardation Act of 1966, namely, Sections 402 and 403 which are under attack in this lawsuit?

(4) A. Yes.

Q. Now, the procedure in those sections primarily permit a juvenile aged 15 or under to be voluntarily institutionalized by his parent or guardian or person standing in a loco parentis while adults less than 18 may release themselves.

Also you have been provided with the additional safeguards which are afforded juveniles which, in part, permits notice to be given them for the reasons of their commitment and the accessibility of an attorney in an event a

juvenile, aged 13 or older, objects to his admission or subsequent thereto.

Now, would you, Doctor, reveal, according to your expert opinion, why juveniles should be treated procedurally different from adults.

A. Yes.

I think that in adolescence you still have a person who has not completed their development physically, continuantly, emotionally and their thinking ability and intellectual ability is not developed yet. They don't have the experience of the world and of what goes on as the adult has.

MR. FERLEGER: Did you say adolescent?

THE WITNESS: Yes. I was talking about the youngster between 13 and 18. I was calling that the adolescent.

The adolescent usually has a lot of hormonal changes, secondary sexual changes, growth changes, epiphyseal changes; some of these don't get completed almost until their (5) twenties, so that there is a—this is still a human being that is still needing care, guidance, attention by parents. They are not able to look after themselves. They have an awful lot of unsettled issues, emotionally among other things, so they are still in need of parental care, parental responsibility; and although at times this is difficult in the adolescent years, it should still be available.

Part of the problem comes up early in the adolescent with the adolescent problem about one continuing to be separate and wanting to be away from home and have his own independence and be quite

autonomous and is still unable to do so. He can't make a living; doesn't have a skill or trade or profession, and the only way that the possibilities can be received is through parental responsibility being carried out and allowing the youngster the opportunity for growth and development to the maximum possible form.

In talking about the normal adolescent who has all these things still to achieve, although he is closer to being an adult and is not a child, we still have the same kind of things that go on in terms of need to be taken care of just as with a child, although they are different. The needs are still there.

Now, with an adolescent who has some other things going on, such an intellectual retardation or has problems of an emotional type, he has some special extra needs. Therefore, (6) he may not be in as good a position to judge things as the ordinary adolescent is whose judgment is not that well settled or that good until he has gone through the adolescent period. So, he still is, even more than a normal adolescent, needs parental guidance, responsibility and so on to be continued until he has passed that point and, if he is incapable of functioning, then he needs even more safeguards which are provided by parents, physicians or whatever institution the youngster may need to be placed in for further help.

BY MR. ROTH:

Q. Doctor, with regard to these procedures, the plaintiffs feel that a judicial hearing prior to a juvenile commitment would best serve the juvenile's interest. Could you, please, comment in your professional opinion as to the

effects of a judicial hearing prior to commitment of a juvenile?

A. Yes.

The point at which a juvenile becomes subject to being considered for admission to some kind of psychiatric institution usually is based on his having some kind of obvious symptoms that lead the people around him to become concerned, become aware that something is going on that needs attention. So that this may be awhile or it may be a very short time after the need arises, but there is some problems, something that is erupting, and the youngster needs some help since he is unable to manage it or do something that could be done to settle it, (7) and if he needs professional help, then this needs to be given to him as soon as possible.

Now, when someone has a symptom that brings someone else's attention to it, it is usually because he wants some help.

Now, the adult, if he wants help, can deal with his own mixed feelings about going to the doctor or not going to the doctor or getting to see the dentist or not getting to see the dentist. He has the understanding and the experience of those situations. An adolescent who is disturbed emotionally has not only the problem of the assessment of his need, ordinarily he also has the problem of assessing it in the light of distortions that he has due to his emotional illness, so when someone has somehow impinged on the people around him to the point that they are saying this person needs some kind of help or this person should be off the streets or this person needs to be getting some help, it is because the person who is having the trouble has finally caused enough trouble or enough distress to those around him so that they respond with concern to do something about it.

Now when that happens, the youngster could dissemble and say nothing is the matter and just try to hide it. This doesn't mean that there is nothing the matter. It means he may be upset about the issue of facing the conflicts; it doesn't mean he doesn't want to have some help. It means that he has some mixed feeling about it; so that when finally somebody (8) in society, whether his family or whether it is the police or the school, finally somebody says this youngster needs help and asks something about it, there is usually a feeling of relief on the youngster's part that finally somebody has heard him and someone is going to do something to help him.

He may object, but that isn't unusual in adolescence for a switf turnabout in feelings and attitudes about something; yet if the person who is charged with the responsibility takes that responsibility, there is a lessening of anxiety, a lessening of the panic state. It may be a lessening of feelings of going out of control or doing something destructive to those around him by acting on this appropriately. Then the youngster is placed in a situation where his needs can be taken care of or begin to be taken care of through the proper, professional approaches.

So, if a youngster needs to be placed in a psychiatric institution because he is threatening suicide or because he is out of control or feels he is going out of control, or feels he is in a panic about to do something disastrous, if somebody says that they are going to make arrangements for him to go into the hospital, then there is some feeling of comfort about it because somebody is going to take care of what he needs to be taken care of.

Now, if there is an intervention of a delay this, I think, would perhaps promote the youngster to having some (9) further difficulties instead of having comfort

about being placed in the proper professional situation. He would have the added anxiety of having a judicial hearing instead of treatment, and he would have the added anxiety of putting off getting something done and to be placed in a proper institution.

I would feel that kind of barrier would add to the youngster's difficulties rather than minimize or decrease them.

Q. Assuming there were a hearing, could you see any trauma attaching to the juvenile when present at the hearing?

A. In several ways: first, there would be the delay which I just spoke of, plus the threat of the court which would sometimes stir up a lot of feelings in youngsters, especially about authority and law and incarceration and so on even though the judicial hearing is being held on their behalf purportedly. The youngster may not comprehend this. He is emotionally disturbed or he may have hallucinations or delusions, so you are not dealing with a person who has all his faculties available. We are dealing with somebody who has a disturbance.

If they don't have that they would not be in that position. So you have that to consider also.

You also have the fact that in a judicial hearing, unpleasant facts may be coming up about his behavior, and it is not a treatment situation. It is not a situation where someone is trying to deal with the conflicts. It is a situation where someone is trying to adjudge them and this always brings up the (10) question in a youngster's mind of right and wrong rather than dealing with his conflicts in the professional, psychiatric approach.

So, I would feel that this would be, for these reasons, adding to the youngster's difficulties.

Q. From what you say, Doctor, I assume institutionalization provides at that point—it provides immediate comfort and immediate protection for the juvenile; is that correct?

A. Yes; although the youngster may still espouse hatred of the place or object to it, he is not in a position to really assess it very well, but deep down, emotionally, he is experiencing some relief and as therapy progresses, you often hear them refer to that initial period of admission as being one of relief mixed with some anxiety. There is always anxiety about making a change. Sometimes you get anxiety about the change brought in, but the change in terms of leaving a bad situation for whatever reason, whether it is actually a bad home or whether it is a fantasy or delusion, there will be some concern about the change, but once the change is made there is relief because somebody is listening, somebody is taking care of the need.

If the need can't be taken care of where he is and he is placed in a situation where potentially the need can be taken care of, then there will be relief.

I have had youngsters express this directly when I have suggested that they need to be hospitalized for one (11) reason or another. Then they have responded with "good" or something to that effect meaning they have grasped the idea that I understand their need and that we are going to do something to try to help them and then they feel very relieved about it.

I have had youngsters when I have seen a variety of impulses about to break through. I suggest that we'd better do something about hospitalization. They feel gratified that I have taken a step towards helping them further.

For instance, if a youngster is a potential suicidal or potentially homicidal, it doesn't mean he is going to kill somebody. It means he feels like he might because he feels

like he will go out of control, or if a youngster feels like he is going to embark on a disastrous course, and when somebody finally listens and takes it seriously, then there is appreciable relief.

This is one of the problems, for instance, with youngsters who attempt suicide; that people don't hear them. They don't take notice of the signs. This is one of the areas where psychiatry has been pushing people in responsible positions to take notice of the thing; from the police officers on down to ordinary family members to note that this or that sign indicates that the youngster is asking for help; that he is suicidal and potentially many lives could be saved just by somebody hearing him at the right time and doing something about it.

(12) I had a youngster the other week who had been wearing his hair long. He came in and he had shaved his head completely, which is quite an abrupt turnabout for him. I took this as meaning something pretty serious, and in the course of the inquiry and during that session he started telling me about some illegal behavior that he was about to embark on. We talked about that, and as we talked it became apparent that he was just about to bust his bubble, so he decided he wouldn't do that illegal act, and as we talked further about the potential destructiveness that he was thinking of, he told me of a fantasy that he had the night before of taking a knife and ripping his leg, which I thought was pretty plain evidence that he needed to be in the hospital. I suggested that to him. I tried to get his family to come along and put him in the hospital. He was ready to go.

He just, I thought, should have had somebody to go in the hospital with him which is around the corner from my office.

He said that he would like to go home and pick up his radio and a couple of things.

It ended up where his father just decided that he couldn't get away from his business to come up and take the kid into the hospital, although he was agreeable to the hospitalization.

The hospital said "Fine, send him in."

(13) He ended up at—he went home. He got his stuff. En route he met some other kid and they had some pot and they had a few other things. He ended up going to the park drinking, smoking pot and while in the park with these two other kids, he ended up committing something which a policeman observed and he pulled him in on the basis of an obscenity in public, and he ended up finally getting to the hospital that evening.

He wanted somebody to make sure he got into the hospital. His father wouldn't. His mother wouldn't, but a policeman finally got him in.

He got into the Central Lockup, and the policeman escorted him into the hospital. That's a long way to get into the hospital.

The father's business had come first. If he had said that his son had come first and he needs to be taken care of, he would have gotten into the hospital that morning instead of going through all this business he did the rest of the day.

So, I think, if you follow that brief clinical vignette to sort of illustrate the point that I am making, the trouble could have been avoided 10 hours earlier.

Now, he has his name on the docket for no good reason.

His behavior that afternoon publicly could have been avoided if he had got right in when I spoke to the father (14) and told him he had to go in.

Q. Doctor, I would like you to comment upon statements that have been made regarding feelings in this case. It has been stated that juveniles "Should be afforded a hearing with counsel present to hear evidence in support of the claim that the juvenile is emotionally disturbed and that such a hearing is not traumatic, and it is much more traumatic to institutionalize a child without a hearing."

Now, can you give us your professional opinion as far as a balancing type of test, if you will, with regard to trauma affecting a juvenile prior to commitment or trauma affecting a juvenile if a hearing is not afforded.

A. I think what I have just said in the last few minutes would cover that point.

I also would think if the youngster has his need bypassed as I have just mentioned, he gets more upset instead of somebody hearing him. He needs this professionally, medically. Then he gets what he might construe as another shuffling around.

I think that perhaps the point of having a hearing may be mixed up with sentimentality. Sentimentality doesn't have any place in treatment because what you are dealing with is someone who is ill rather than romantic notions. So, if he is ill, then we start treating him by putting him in a place to take care of him. The hearing should not be put off forever if the youngster wants a hearing. Then you have that as part (15) of the law. Then he can still have recourse to that.

Q. It has also been stated, Doctor, that "Juveniles are institutionalized as mentally ill when their acts may be defined merely as juvenile delinquency."

A. Well, juvenile delinquency is a rather broad term.

Delinquency refers to an act that someone has been caught doing.

Most youngsters commit something illegal at some time. This is part of their growing up and learning right and wrong.

Most youngsters do a little stealing in their early grade school years. They do a little lying. They may break windows and run away and never be caught. You don't call them delinquent. They have never been caught. They committed something they should not have done, but the youngster who continues and doesn't learn right from wrong is having a symptom of some emotional disturbance to whatever degree it is. It is a symptom.

If he is stealing, if he is truant from school repeatedly, running away from home, these are symptoms of something emotional that has gone awry. So, the fact that it may just be a symptom doesn't mean it should be neglected. It may be a symptom of something quite serious. It may be a symptom of schizophrenia. It may be a symptom of a psychosis of another kind. It may be a symptom of something that hasn't gotten quite organized into a specific neurosis, but there is a tendency (16) toward this. It means that there has been some kind of emotional deprivation, very serious at some point in the youngster's life, and this represents his attempt to deal with it emotionally through this behavior.

Behavior has means. If we can understand the meaning of that, we understand something about the antecedent that led up to it. It may have happened 10 years before, but it is still continuing on because it hasn't gotten settled, so there is still a conflict, and the youngster's behavior is looked on as a symptomatic act of this disturbance just like if we have a fever. We know that there is something the matter in the body at that time. There is an inflammatory process. It may be due to infection. It may be due to

physical trauma, maybe malignancy. It means something is going badly someplace in the body physically.

If we have a symptomatic act of disturbed behavior whether it is called a delinquent act or whether it is called a delusion, it is an act or—it is a set of beliefs that are representative of something emotionally disturbing that person.

Q. Are you familiar with the concept enunciated in Ray Gault?

A. Yes.

Q. Doctor, that case reveals in part that "Juveniles who may be tried for a criminal act shall be afforded counsel."

An anology has been made in this case that juveniles were deprived of their liberty for a criminal act or for (17) emotional disturbance or emotionally disturbed behavior should be afforded a hearing prior to commitment.

Can you comment in your professional opinion upon the distinction between juveniles committed for criminal acts versus juveniles committed for emotional disturbances?

A. Well, sometimes you will have juveniles who have committed criminal acts because of emotional disturbances.

Sometimes you have quite a malange of the two, but as I understand that Gault case, that was a case where a youngster had a complaint lodged against him by an adult on a illegal basis and the youngster was going to be sent up to an institution without any further hearing because he was a juvenile.

There was no involvement there of medical process. There was no diagnosis made. There was no assessment of his act made medically.

There was a judicial process, and that link is a somewhat different situation when there is a medical need because the situation of that is quite—since in the hearing of the youngster's act it was adjudged as criminal without a counsel being present; in a medical situation you don't have somebody admitted to an institution just on the parent's say-so or the law officer's say-so.

You have the youngster admitted on the basis of a medical examination. Some psychiatrist has examined him. He isn't just admitted because somebody says that he should be (18) admitted.

If I send somebody into the hospital they are not admitted to the State institution because I say so. They may be presented there, but the admitting physician at the State institution still has to do his own examination, and if he says this youngster needs to be admitted, then they are admitted.

So, there is protection of a youngster because there is professional, medical opinion that is held responsible for the admission.

Q. Do you feel as a professional, of course, that you are satisfied with the voluntary admission and commitment sections of the Pennsylvania Mental Health Act and Mental Retardation—

A. It allows for the youngster's needs to be taken care of medically so he is protected that way.

I think it allows for cases where the youngster has objections to bring him to the attention of the proper authorities to a judicial hearing that is allowed. I think it allows the youngster to get the parental protection and the parental responsibilities brought to their fullest to his needs in this way. So, the youngster is protected, I think. The parental rights are protected and the youngster's rights are protected.

Q. Doctor, do you often testify in court cases?

A. I have in the past. I have not in the last few years.

Q. You have?

(19) A. I have not in the last few years, not at all.

Q. Are you being compensated for your testimony today?

A. Yes.

Q. Are there any other comments you would like to make, Doctor, knowing the nature of this case?

A. Yes.

MR. FERLEGER: I object. I think it is improper to simply ask a question inside a question. If you have a question to ask, you should ask him a question rather than asking for his general comments about the nature of the world.

MR. ROTH: You can note the objection.

The question remains.

Do you have any comments with regard to the regulation or acts involved and your feelings towards them and towards the nature of this case?

THE WITNESS: Yes. I have some other comments to make relative to the last question.

In my view, the way the current law is arranged, the youngster is protected. His needs are taken care of medically. The parental rights are not abrogated, and the due process is available in due time.

I think if he has changed in a way, that is, perhaps being suggested by the action in this case, there is perhaps a danger that the parental protection of the

youngster will be removed which means the State then becomes in charge of the (20) adolescent and raises them and that the law makes the diagnosis instead of physicians.

I think this would be a travesty for the adolescent development and medical care.

Q. Doctor, let me ask you one more question with regard to this case: It has been said that "Institutions are used as dumping grounds by parents for placing their children in institutions for reasons other than children should be placed in institutions."

MR. FERLEGER: It should be noted, for the record, that it is Chief Justice Berger of the Supreme Court who said that.

THE WITNESS: Who said what?

MR. FERLEGER: That "Families use mental institutions as dumping grounds for unwanted members of their families."

BY MR. ROTH:

Q. With all due respect for the reporter, when Mr. Ferleger wishes to cross-examine, he can, and in regard to that statement it also should be noted that that was made in a dissenting opinion by Chief Justice Berger; nonetheless it has been stated that these institutions are used as a dumping ground for parents and the parents farm their children out.

Now, do you know, from your knowledge, personal knowledge and background—would you comment about that?

Perhaps the abuses of the system and why you still (21) maintain that the system, as you know it, in Pennsylvania is sound. Would you comment on that.

A. There are a number of considerations in that. I would think that one of them has to do with the fact that physicians are liable to error just like any other humans. They can make a mistake in a diagnosis. They also may get distortions consciously, or otherwise put into the situation by the parents or by the youngsters so that they don't get a pure picture of the behavior of the symptoms of what has been going on. Those are, I would think, very small in number, and I don't think that is cause enough to change the structure.

I think it behooves us to try to be more meticulous in our diagnosistic assessment and be careful in scrutinizing the situation of each case as it comes up.

Also, I would think that by and large parents do protect their youngsters and do look after them fairly suitably because, as it stands now, we have maybe—well, let's say, roughly 10% of adolescents who are in need of some kind of psychiatric help. I think if it were that parents were not doing a pretty suitable job it might be reverse and it may be 90% would be needing psychiatric care and 10% would be functioning fairly well.

Now, on another point which I think needs to be brought in, there are situations where the family resources are just strained and they are drained and they just can't function (22) with a psychotic child or can't function with a severely retarded child, and even though ideally it might be best to have that retarded or mentally retarded child at home or a psychotic child at home, they just don't have enough resources. They are not capable themselves emotionally to handle the youngster at home, or it may be having quite a deleterious effect on other members of the family, or it may be in some way interfering with the father's being able to attend to his income-gathering pursuits, so that the family may end up on Welfare.

The father has to stay up to restrain a 15-year old boy who is quite actively destructive around the house and protect the rest of the family from his behavior that is undesirable. That means he can't go to work. So, in some of those situations, the total family functioning has to be assessed emotionally on the drain and strain on them.

There are also cases where some people just don't fit into the family scheme; the family is trying to function in one direction and the adolescent is so disturbed he just cannot fit in, and what he is doing is very much against the family function optimum. He needs treatment in a special place.

I would think that those are at times symptomatic of the youngster wanting help and being in a position where he needs to go to an institution to get help. He can't function. He can't fit in with the family for whatever reason.

So, I would think that the question of a dumping (23) ground and an abuse of that sort of thing—I don't know of any statistics that anybody has presented about that kind of thing, but I know from time to time those things have happened.

On the other hand, there are some parents who physically abuse their own children and cause skull fractures and almost kill them sometimes when they are just two or three or four years old and, there are efforts being made to try to curb that and to find those cases and take the child away from the parents because the parents aren't able to look after them properly, but still even in those extreme cases there are a very small proportion of parents, which means that there are situations where parental responsibility is not being fulfilled properly and then someone has to step in and take over.

The diagnosis of those situations is made by the doctor.

The child abuse cases are diagnosed by a doctor, and then the law is brought in to assist in proper placement of the child away from this home; not to hurt the child, but to help him survive.

So, if you take that as an extreme case, there are other cases where the youngster has to be in an institution so he can survive emotionally.

Q. Doctor, with regard to something that could be placed back in your qualifications, are you a member of any associations?

A. Yes.

(24) Q. Could you give us the names?

A. The American Psychiatric Association; The American Academy of Child Psychiatry; The American Society of Adolescent Psychiatry; The American Orthopsychiatry Association; The Southern Psychiatric Association; Orleans Parrish Medical Society; Louisiana State Medical Society; American College of Psychiatrists.

I think that's it.

MR. ROTH: I think that covers it.

I have no further questions.

BY MR. FERLEGER:

Q. Dr. Sugar, I am interested by your comments that the use of the law in mental health situations can sometimes, in your opinion, make the diagnosis, which is to occur, be accomplished by the law rather than by a doctor.

In Louisiana, are there procedures by which adults can be institutionalized in a mental hospital without a prior judicial hearing?

A. Yes. They can admit themselves voluntarily.

Q. Are there procedures for involuntary commitment for adults without a judicial hearing?

A. No. It has to be based on a diagnosis first.

Q. So, in those situations, once a doctor has made a diagnosis, the doctor makes that diagnosis to the Court and then it is a legal question whether or not the person is mentally ill or needs to be institutionalized; is that correct?

A. (25) It's based on the diagnosis given by a psychiatrist.

Q. And the decision is made by the judge?

A. Yes.

Q. So, your position is not that the Court shouldn't at all be involved in the commitment of juveniles, your position is that the Court should rely on or make use of the diagnosis and expert opinions of doctors; is that right?

A. Yes.

Q. Now, in Pennsylvania, except in emergency situations when children or adults could be committed without any delay whatsoever, when an adult is to be committed to a mental institution, the law provides that there be a prior judicial hearing.

Now, is it your opinion that that prior judicial hearing is the kind of sentimentality of the law that you mentioned with regard to children?

A. I don't think I understand your question.

Q. Do you favor, as an expert, a prior judicial hearing before an adult is committed to a mental institution?

A. No. An adult can be committed without that in case of emergency.

Q. Okay.

In the non-emergency situation—

A. Yes.

Q. Do you favor a prior judicial hearing for adults?

A. Not necessarily.

(26) I have seen some rather difficult things for the patient where there was that kind of thing and was very embarrassing, very painful to the patient.

Q. So, there are some non-emergency situations where you would feel, in your expert opinion, that there ought not to be a hearing even for an adult who is going to be committed?

A. Yes, where the adult objects and seeks counsel and wants to have the hearing in that case, this is what the law provides.

Q. Even though in your opinion it shouldn't be necessary?

A. Well, I don't think I was addressing myself to that.

Q. Well, that is the question I am asking you.

Are there situations where an adult needs hospitalization in a non-emergency situation in that kind of circumstance? Do you feel that a prior judicial hearing is appropriate?

A. I think, as I understand it, the judicial hearing in those cases, is utilized to provide admission to the adult because he refuses to accept the recommendation, so, therefore, the law is utilized to implement the diagnosis and the recommendation therefrom. So, I feel, yes, it needs to be utilized.

Q. There are situations, aren't there, where the prior hearing is used in order to incarcerate the person for the purpose of getting a diagnosis; isn't that right? Isn't that what the Pennsylvania law provides?

A. To incarcerate a person, no.

Q. For the purpose—

(27) A. Of making a diagnosis?

Q. For the purpose of obtaining a diagnosis.

A. I would hope that the diagnosis had been made before, and I don't see that that would be a proper pursuit of medicine to have someone incarcerated to make a diagnosis.

Q. Even though that is what Section 406 (a) of the Pennsylvania Mental Health Act provides? Do you think that part is improper?

MR. ROTH: Objection.

THE WITNESS: I don't understand how that comes into what I understand of the Pennsylvania Law.

BY MR. FERLEGER:

Q. Well, the Pennsylvania Law provides, doesn't it, "That a person may be committed involuntarily to a mental hospital by a Court without any diagnosis having been made; that commitment being for the purpose of making a diagnosis"?

Now, I understood your testimony to have been that in your opinion that would be an improper role for the law to play; is that right?

A. My opinion was that the youngster could be admitted.

Q. I am talking about adults now.

A. I thought the case was about adolescents.

Q. My question is about adults.

MR. ROTH: I think you are confusing the doctor in terms of what you are revealing about 406. If you want to give him a little more background, you know, so he is not (28) confused and misled in attempting to answer—

MR. FERLEGER: I will repeat my question.

BY MR. FERLEGER:

Q. Pennsylvania Mental Health—the law provides "That an adult may be committed involuntarily to a mental institution as a result of a judicial hearing prior to there having been any involvement of any psychiatrists or any medical opinion with regard to that person's condition."

That commitment under Section 406 (a) of the Mental Health Act provides for an "evaluation or a diagnosis to be made after that involuntary commitment."

A. I see.

Q. Now, I understood you to have just testified that you consider that kind of commitment or incarceration without a doctor having been involved to be inadvisable; is that correct?

A. No.

I think in that kind of situation, just as I was saying before, somebody makes enough trouble, somebody becomes enough of a nuisance, somebody takes notice and somebody takes proper action.

If somebody gets out on top of a building and says he will jump—

Q. We are not talking about emergencies.

A. Well, I am only giving you an illustration to make my point.

(29) If someone gets out on a building and says they are going to jump and they have been telling their family for weeks how depressed they are, when they get on top of the building somebody starts to notice.

So, the point is the police are brought in immediately.

Q. We are not talking about an emergency.

A. I'm talking about the fact that someone is doing something to bring him to someone's attention; that they need help, and the ordinary man in the street can tell that

somebody is walking with a limp. The ordinary man in the street can tell if someone's behavior is at odds with the usual behavior in that culture.

So, in that case somebody has some concern for someone's safety and someone's well-being. The law acts to protect the person.

Q. What is the need in that case to have a judicial hearing?

A. Since someone is taking someone else's needs as being something that needs to be attended to—

Q. Isn't the need for a juducial hearing to have an independent person find out whether the facts are as alleged?

A. If in that case you are talking about where there has not been a psychiatric evaluation—

Q. That's right.

A. The law says admit for the purpose of an evaulation since this person's behavior in some way is at odds with what the (30) usual is.

Q. Well, is there any reason for there not to be a procedure whereby the person to whose attention his symptoms came could apply for the potential patient's admission to the hospital without involving a judge?

A. Do you want to repeat that. I think I lost some of the posture there.

Q. Why not have a situation where, for example, the wife whose husband has been acting bizarre lately can apply to the mental hospital and say that my husband has been acting in such and such a way and I feel he neeeds some evaluation—would you support that kind of procedure?

A. And the patient is accepting or rejecting?

Q. Rejecting it.

A. Well, I understand that is what the law does allow for.

Q. The law does not allow that for adults. It allows that for children.

A. Yes.

Q. Is it your position that that ought to be allowed for adults as well?

A. I don't quite see what you're getting at.

Q. I'm trying to get you to answer a question.

MR. ROTH: Why don't you state the question, David.

BY MR. FERLEGER:

Q. Is it your position that the law ought to provide that (31) this hypothetical wife should be permitted to have her husband involuntarily admitted upon her application and description of his bizarre behavior to the psychiatrist at an institution?

A. No, because the psychiatrist then would do an evaluation before he would commit him.

With no evaluation before, then you have the law to allow for a judicial hearing.

Q. And if there would be an evaluation by the psychiatrist—suppose the law would provide that two psychiatrists should evaluate this involuntary husband, and if their evaluation indicated that he was mentally ill and could benefit from treatment, would it then be your position that he ought to be involuntarily committed to the institution?

A. Yes. There would be enough evidence on that basis to provide a substantive diagnosis and recommendation for hospitalization.

Q. All right.

So, based on that two-doctor recommendation, are you then supporting the law—

MR. ROTH: I object to this line of questioning because what you are trying to do with the doctor is trick him because you know of a case involving recommendations by two physicians was deemed inappropriate and unconstitutional; and Dr. Sugar is not familiar with all the Mental Health Laws of Pennsylvania. He has familiarized himself with the sections in (32) question, and I think it would be appropriate to address the sections in question and with regard to his opinion of those and the treatment of juveniles versus the treatment of adults and the procedure after safeguards afforded each. I do think it is inappropriate. I think it is misleading. To attempt to secure from Dr. Sugar an opinion, fine. He can give us his professional opinion, but with regard to things that he may feel should be acceptable which have been declared invalid, is really irrelevant to this lawsuit.

MR. FERLEGER: You know perfectly well, Barry, that it is perfectly relevant if Dr. Sugar is sincere, honest, professional opinion is that procedures ought to occur which, in fact, the laws and the courts have ruled cannot occur.

If his opinion is that certain procedures which are unconstitutional or medically proper—I think that is highly relevant to the lawsuit, and if as Dr. Sugar has stated his opinion, that doctors after doing an evaluation should have the power to involuntarily treat people, that is very relevant to the lawsuit.

This lawsuit involves equal protection as well as due process claims; the reasons for the difference in treatment of adults vis-a-vis children are also relevant.

MR. ROTH: And that should be the major focus with regard to the treatment and the procedures afforded juveniles versus afforded adults.

(33) MR. FERLEGER: You can't tell me what my question should be.

MR. ROTH: I know. But I am objecting just the same.

THE WITNESS: I would like to point out that I came here prepared to talk about juveniles and the nature of juveniles and their special needs rather than adults.

BY MR. FERLEGER:

Q. The nature and difference between juveniles and whom?

A. Adults which, I think, I explored earlier in some detail about this development and their function being incomplete.

Q. Dr. Sugar, did you come here to speak about—strike that.

MR. ROTH: Well, I object again and—

MR. FERLEGER: He can make any statement that he wants under examination by you. Right now it's cross-examination.

MR. ROTH: Fine.

There was a comment that you had made to him and he had replied to your comment and you seemed to have rapidly cut him off.

MR. FERLEGER: No. He was not replying to any comment of mine, and the record will show.

BY MR. FERLEGER:

Q. Dr. Sugar, you consider yourself an expert in adolescent psychiatry or child psychiatry as well and younger children, do you not?

(34) A. Both.

Q. You made a number of comments earlier with reference to adolescence; the fact that there are hormonal changes and growth changes, sexual changes that don't get completed until their twenties.

Now, isn't the picture a little bit different with regard to persons who were, for example, under 13, for example, not adolescents?

A. What picture?

Q. Their psychiatric status.

A. I don't know what you are asking.

Q. Well, all your comments about adolescents do not necessarily apply to younger children; isn't that correct?

A. Well, not all of them, but generally they do apply in that there is still growth. There is incomplete, physical and emotional development in younger children, and that they're in need of someone to care and be responsible for them.

Q. Now, Dr. Sugar, you commented that it is your estimate that about 10% of children need psychiatric help; is that your estimate?

A. I wasn't making an estimate. I was just using that as a figure for the purpose of my comments.

Q. What is your estimate of the number, the percentage of children who need psychiatric help?

A. I don't have an estimate of that. I don't have a figure (35) handy to give you. We can look it up in the literature, if you want.

Q. Do you have any estimate of the percentage of parents who need psychiatric help?

A. It's been stated about 10% of adults. It's been stated about 10% of children, but I couldn't give you that as a specific, accurate figure. I am just saying that is a round figure.

Q. Now, Dr. Sugar, one of the questions involved in this lawsuit is how much reliance should be placed upon the parents' evaluation or reporting of various behaviors of children.

My understanding is that it is your testimony that a substantial reliance should be placed upon the parents; is that correct?

A. On whomever they are living with. We assume for the purpose of this discussion that it is the parents.

Q. Okay.

Parents or guardians or whoever.

A. Yes.

You can also utilize data from other people that the youngsters are involved with in a substantial sort of way.

Q. Would it be your position then that commitment to an institution could be made on the application of other people besides parents, guardians of people in loco parentis?

A. Well, I think that covers it.

Anybody who is in loco parentis for that moment (36) can take action to protect the youngster.

Q. So that a child—while a child is in school, do you think he ought to be permitted to be committed by a school official without regard to the parents' wishes?

A. If the child is in a boarding school.

Q. I am talking about a regular public school.

A. I think I am not really saying that at all.

Q. You mean a boarding school?

A. Yes.

And he is in charge of loco parentis of someone else and they have responsibility to look after the child.

If the child suddenly is exhibiting bizarre behavior destructive in some way or other to himself or others, they have responsibility to exercise protection for that child.

Q. How about in the non-emergency situation? Do you think that the boarding school ought to be permitted to commit a child without the wishes of the parents?

A. I would assume that they would contact the parents. I would assume that they would do something procedurally proper to get an evaluation.

Q. I'm asking you what you feel psychiatrically.

A. Well, that's what I would feel would be the more psychiatric approach.

Q. That the parents should be contacted?

A. The boarding school should contact the parents. The (37) parents should seek appropriate evaluation and appropriate steps should be taken.

Q. It is your testimony, is it not, that you feel that parents or people in loco parentis ought to be substantially relied upon for the reporting and noting of various behaviors of the children?

A. Yes. They are the ones who have the most contact with the youngster.

He is living with them and spending most of his time with them. So, they're able to observe his behavior and changes.

Q. Now, with regard to situations in which there is disagreement between the potential patient and the parent, who is it that you think is in the position to figure out what the actual facts are? Is it the physician or psychiatrist?

A. I would think so. I would think that he should try to assess the situation from both sides and weigh the data and the observations of the youngster's mental functioning. That is what he is trained for.

Q. I might have misunderstood your testimony, but I understood you to have testified that many so-called juvenile delinquents, juveniles who commit behavior that the law considers criminal, that many of them also have emotional problems; is that right?

A. Yes.

(38) Q. Now, when a juvenile delinquent—that is a juvenile accused of some criminal act, and assuming the juvenile also has emotional problems, when a decision has to be made about what kind of rehabilitation has to be done for that child or whether, in fact, a juvenile actually did commit that behavior, who, in your opinion, should make that kind of decision?

A. I don't quite understand.

Q. Who?

A. If a juvenile has done something?

Q. When a juvenile is accused of a criminal act and that juvenile is accused in juvenile court of that criminal act, somebody has to decide whether or not that juvenile committed that act; is that right?

A. Yes.

Q. Now, the juvenile may have one story. His mother may have another story and the shopkeeper might have a third story; isn't that possible?

I didn't hear your answer.

A. I didn't answer.

Q. Well, can you answer?

A. I'm still listening to your question.

Q. My question at this point is it is possible, is it not, that the juvenile will have one story, his mother will have another story and the shopkeeper, for example, might have a third story?

(39) A. Yes, it's possible.

Q. Now, who, in your opinion, should decide which of those stories is true or what facts actually occurred?

A. I think that that is really a question that I couldn't give you an opinion on since you are saying it is a criminal case. He has been apprehended. Somebody has charged him with something. I don't think that is a medical case at that point.

Q. It is a case in which the facts have to be decided by a court; isn't that right?

A. Yes.

It is a court case at that point. It may be a medical case later.

In other words, if the assessment of what is going on leads someone to start thinking that this behavior is connected with something of an emotional disorder, then the Court would, I presume, would call on psychiatric consultants to do an evaluation.

Q. Now, Dr. Sugar, in a situation where a juvenile is accused by a parent of, let's say, acting in a hostile or retaliatory way toward a parent or juvenile and is accused of some bizarre behavior such as ripping up all the books or toys in a room or some other strange kind of behavior, isn't the first question for a psychiatrist whom this comes to the attention of, isn't the first question whether or not that behavior occurred and then if the doctor decides the behavior occurred, the question is (40) medically what is the diagnosis and the best course of action? Isn't that the process that you follow as a psychiatrist?

A. It varies according to the individual situation.

Q. In the case that I gave where a mother comes in and says that "My child has been doing all these strange and bizarre things," isn't one of the things you want to know immediately whether or not that is true?

A. Well, I would hope to get that data in the course of the evaluation. Whether I would get it in the first or ten questions is beside the point.

Q. You feel that is important information for your evaluation?

A. I would like to have the youngster's tale about what he thinks is going on.

Q. Do you understand that the purpose of this lawsuit is not to exclude psychiatrists from the picture altogether, but to have that factual evaluation done by a Court rather than a psychiatrist? Do you understand that that is the purpose of the lawsuit?

A. I really don't know what you are trying to ask me with that question.

Q. I am asking whether you understand that that is the purpose of the lawsuit.

A. To do what?

Q. To have a Court—

(41) A. Assess—

Q. —make that factual determination.

A. Of whether the kid did do or didn't do something?

Q. That is correct.

A. In a non-criminal case?

Q. That's correct.

A. And thereby seek to do what?

Q. I'm asking you if you understand that the purpose of this lawsuit is not to exclude psychiatrists?

A. "Altogether," you said.

It sounds like you are saying you want to exclude psychiatrists.

Q. Well, that is what I am trying to explain to you and clarify because, evidently, you have a misunderstanding from the defendants' counsel.

A. I didn't say that. It's my understanding—my understanding is—by the way, you are suggesting that you are delaying getting help for the youngster when he needs help. That is my point.

I was not saying what you were just quoting me as saying at all.

Q. Do you understand that the purpose of this lawsuit is to have those factual questions decided by a Court?

If that is not your understanding of the lawsuit, just answer no.

(42) A. I don't understand what you are saying really since my understanding of it was having to do with the judicial process preceding psychiatric attention.

Q. Your understanding is that this lawsuit involves a delay in obtaining psychiatric care for juveniles?

A. Yes.

Q. Now, can you explain why you feel that the emergency commitment provisions of the Pennsylvania Mental Health Act are not sufficient to get around the problem of delay in obtaining needed treatment for juveniles?

A. Well, sometimes they may not be of a level that makes them seem of an emergency basis to the casual onlooker, whether it is the family or anyone else.

Q. Isn't that also true of adults?

A. Somewhat, except that adults have more means at their disposal to do something for themselves, whereas

if a youngster is assessed as having some problems and the family takes him to a psychiatrist and the psychiatrist says this kid needs to be in a hospital—

Q. Except we are talking about adults that may be severely disturbed.

A. I really don't understand what you are getting at.

I am lost again.

Q. Dr. Sugar, —

A. I seem to have trouble following what you just said.

(43) Q. Dr. Sugar, for adults who may need or may not need psychiatric help, adults who exhibit some strange or bizarre behavior, isn't it true that in non-emergency situations delay may also be not advantageous to that adult's mental condition?

A. Yes.

Q. And it is true for children as well that delay can be a problem?

A. Yes.

Q. Dr. Sugar, are there situations where parents can be antagonistic or disruptive to what may be beneficial for their children's mental health?

A. Yes.

Q. And it's true, is it not, that there are situations where parents have psychotic children by obstructing or resisting attempts to help their children?

A. Yes.

Q. Am I correct?

A. Yes.

Q. If parents behave in that manner, you are not suggesting that they ought to be the ones who make the application to mental institutions, are you?

A. Well, usually, unfortunately they are the ones—they try to disguise the situation, but if the child goes to school or is in some way—at some times he is outside the home, it may come to someone else's attention, in which case, some (44) representative of society like the law may suggest something be done about it, or if the kid is picked up shoplifting 10 times and the parents don't see anything the matter with it, somebody may say this youngster needs to be put into a youth center by the law and then evaluated psychiatrically because the parents aren't doing something. They are not assessing the situation properly.

Q. Dr. Sugar, you have testified about a number of children who have expressed to you the anxiety and relief that children often feel about being institutionalized. For that sort of child, is it your opinion that he or she ought to be allowed to commit himself with the doctor's approval?

A. In that case the doctor takes the position of loco parentis.

Q. All right.

So, if a child wants to be given professional psychiatric assistance and if psychiatrists or a hospital believes that that child is in need of assistance, you would approve procedures whereby the child could then get assistance?

A. That's the law in terms of loco parentis. Someone would do something on an emergency basis.

Q. That would even be if the parent was one of the parents who felt that psychiatric care wasn't necessary?

A. If it was an emergency, yes.

Q. How about if it wasn't an emergency?

(45) A. Then you have a question of the law, and someone has to be responsible to take the child away from the parents to do something, just like in child abuse cases.

Q. In your expert opinion in a situation where the parents don't want treatment, but enough psychiatrists and the child both feel that treatment is needed, you feel that the law and the Court should be involved at that point?

A. For the protection of the child, yes.

Q. Thank you.

Now, it's true, isn't it, that very often parents may misinterpret behaviors of their children and feel that certain actions or what doctors would call symptoms, symptomatic behavior, are more serious than they actually are; isn't that correct?

A. Yes.

Q. There may be situations where, for example, a mother might feel that a child is attacking her even though that is not true?

A. Yes, that could be.

Q. And in a situation especially where the parents might be having some problems among themselves, that kind of information from a mother to a psychiatrist would not be very reliable; isn't that correct?

A. It would have to be weighed against the total situation, sure. The mother might be psychotic herself.

(46) Q. And it's true, isn't it, that in situations where the parents may be having problems, children may be subject to extreme deprivation of their emotional and their physical needs; isn't that right?

A. Yes.

Q. And in that kind of situation, would it be your opinion that the law ought to permit the parents to initiate institutionalization of children?

A. If the child needs institutionalization, then the parents aren't capable of making an accurate assessment. Someone needs to be able to step in to do something about it.

Q. And to make that assessment?

A. And to get the assessment done, yes. Somebody needs to evaluate that.

Q. Now, the difference in our opinions evidently, Doctor, is that you feel that solely doctors should be involved in making that assessment and the plaintiffs feel that the facts ought to be determined by the Court, and that the doctors ought to determine the psychiatric implications of those facts.

Now, in that situation where the parents might be in turmoil or conflict, where the child might have behaviors that are reported by the parent to the psychiatrist, do you see any reason in a non-emergency situation which Courts and psychiatrists couldn't work together to determine what is best for the child?

(47) A. I have no objection to the Court and psychiatrists working harmoniously together.

Q. Because in that kind of situation it is true, isn't it, that it may be impossible to get the parental cooperation that is needed for the best interest of the child?

A. It may be, in which case it may be useful to have the child put into another home or an institution where they can be evaluated and observed properly.

Q. And should that decision be made by a psychiatrist or a Court?

A. Well, that decision would initially have to be made by the law since someone has to bring it to the legal attention; the police or the Courts would have to do something to prevent the child suffering further. So, the first step would be someone noticing the behavior being not ordinary anymore and someone needs to then put the child in a safe place where they can then be evaluated.

Q. Doctor, would you, please, give me your opinion about the extent of mental illness among parents of mentally disturbed children?

A. I don't have a figure on it.

Q. Well, in your experience—

A. I don't have a figure.

Q. I am not asking for a figure. I am asking for your estimate or evaluation.

(48) A. Well, you are asking me for a figure. I can only say it does happen. I don't have figures to supply you with at this moment.

Q. Is this frequently or infrequently?

A. It depends on the nature of the situation.

If the youngster is severely ill, is a psychotic kind of youngster, there is a tendency perhaps to find a somewhat higher percentage of serious illness in the family.

Q. It would be a tendency then for psychotic children to come out of a family situation in which one or more of the other family members might also have serious mental problems?

A. There would be a tendency, yes.

It's not a genetic kind of factor at this point as far as we know, although some people feel it is, but it is not generally accepted.

Q. Isn't it true that it often happens that the behavior of adolescents which might be quite typical and normal for adolescents might frighten a family unduly?

A. No. I wouldn't think so, no.

Q. Would it frighten the family into being sort of overly concerned about the behavior of the adolescent?

A. I wouldn't think so unless there is something bizarre about the behavior—unless there is something bizarre about the parent.

Q. Well, if the behavior was so bizarre in the parent's eyes, (49) isn't it true very often that might be simply normal adolescent behavior?

A. It might be, depending on the parents' set of values and vantage points, sure.

Q. Well, if that bizarre behavior occurs, isn't it true that the parent—that the child might appear frequently more disturbed than he is and may frighten his family?

A. Potentially in that case where there is that kind of distortion in the parents.

Q. Potentially—or isn't that absolutely true?

A. I don't feel we can make that kind of comment at this point.

Q. When you wrote your article in the American Journal of Psychotherapy, "Normal Adolescent's Morning," didn't you make that very statement?

A. Do you want to quote it to me? I don't recall it.

Q. You stated that "When bizarre behavior occurs during a distortion phase the adolescent may appear to be more disturbed than he is and might frighten his family."

A. Yes.

What I was referring to there was a brief episode of something strange or unusual. The youngster has a reaction to something and he has a strange kind of response, and the parent may feel frightened about the thing temporarily.

Q. And during that temporary, frightened phase, isn't it (50) correct that the parents might decide incorrectly that the child needs psychiatric help?

A. They might; but what I was referring to in that article was a temporary phase, which means, that the usual course of it is that the parent sees a fluctuation in this.

If you recall the rest of the point I was making there it had to do with this being a fluctuating situation.

Q. Let's read it.

A. Therefore, it would be something that would become altered, and the parents might not continue with their frightened response.

Q. But the other thing that can happen—isn't it that the parents might withdraw and not even realize that the child needs help?

A. Yes, they might withdraw.

Q. And then—

A. They might overreact and say "Let's rush to the psychiatrist."

Q. If they withdraw, in that case the child would be deprived possibly of needed psychiatric help?

A. No. If that is put in the context in which I was writing, just on the basis of that kind of thing in a normal process, this would get taken care of by itself through the usual developmental processes going on. Therefore, they would not be depriving the youngster of what they are ordinarily doing for him.

Q. But it is possible, isn't it, that, for example, that (51) the child may speak to a physician and the physician may side with the parents, and in that case, the child may be deprived of help?

A. Sure. It's possible. He might not recognize the situation for what it really is, sure. Errors can be made.

Q. You stated in your article, didn't you, about the parents' bizarre behavior and that the child—that they may then withdraw or react antagonistically and miss the adolescent's real need of help through supporting controls.

If the physician identifies himself with the parents he may also lose sight of the basis of the adolescent's behavior; is that right?

A. Yes.

Q. So, there are situations then where the doctors wrongly identify them with the parents' side of the picture?

A. They identify with one or the other, and this may lead to difficulties, yes. This may happen since everyone is subject to error. That is my point.

Q. In a situation where parents are having some marital problems and—

A. Excuse me. Let me just go back to the point that I was making about withdrawing. I was referring to that in terms of a technical sense of not giving the youngster control and support. They just say something very negative or sort of say "You are on your own" or boot him out, and their response to their (52) behavior instead of realizing what it means—withdrawal means—this is not a withdrawal of monetary support. They just don't understand. They don't control and let him understand that they are still there to look after him.

Q. But there are situations where the withdrawal may result in a withdrawal of physical needs as well?

A. Yes.

Sometimes parents overreact to that degree also.

Q. You stated, as a matter of fact, in your article "Divorce and Children" in the Southern Medical Journal that with reference to divorce "The subsequent guilt or change in their matrimonial fortunes might leave the child unattended even to minimal, emotional or physical needs."

A. Yes.

Q. Further, "Confusion results from this oscillation between overindulgence and deprivation."

A. Yes.

Q. So, especially in the course or other unstable situation we come across cases where the parents can't really be depended upon to look after the best interests of their children.

A. Right, because they are in a stressed state themselves for that period of time, yes.

Q. And you might have situations, might you not, where the children's symptomatic behavior is a result, not simply of the child's own internal problems, but a result of the turmoil in (53) the family?

A. Yes. They have a reactive response to the situation.

Q. In fact, the story you told about that boy who got into trouble just, I think you said in the past week or two, his situation was one in which you testified that his father and his mother wouldn't step in to help him get hospitalized.

A. Well, they accepted the hospitalization. They wanted him to be hospitalized. They didn't do the extra little step which would have safeguarded him.

Q. Which would have kept him from getting arrested?

A. Right.

Q. It's true, isn't it, that in this divorce or unstable situation that the parents—well, let me quote from your article and you can tell me if you still agree with it:

> "Parents may interpret the child's behavior as retaliation due to their own feelings of guilt about having broken up the child's 'happy?' home, but the child usually is not deliberately revengeful and his

responses need to be viewed in the context of feeling hurt, frightened and angry about the loss and his need to let the parents know about this."

Do you still agree with that statement?

A. Yes.

Q. So that there may be situations where psychiatrists or institutions are confronted by parents who might simply give (54) their view of the behavior of the child without explaining the possibly, embarrassing marital situation and where psychiatrists might, in an unwarranted way, side with the parent before they can find out the actual picture?

A. Well, no.

I would have to qualify that statement in terms of a psychiatrist's job. It is to assess a child's functioning and what is going on with him emotionally, not just on the basis of the parent's complaints, but on the basis of evaluating the child and getting the child's story about what he feels and what has been going on and assessing his mental status and then coming to some diagnostic appraisal.

Q. And that assessment also involves assessment of the facts?

A. It involves an assessment of the facts; involves an assessment of what the parents are really saying as well as what the child is really saying. Hopefully, this gets to a more accurate appraisal diagnostically.

Q. Can you tell me what, in your opinion, or by your training gives you the extraordinary qualifications to decide what facts are true as opposed to the mental status?

A. I am afraid I don't understand what you just said.

Q. Well, in evaluating—

A. Since nobody claimed extraordinary kinds of powers which you are imputing—

Q. Well, have you ever participated, Dr. Sugar, in the (55) commitment of an adult?

A. Yes.

Q. Have you ever been in court during a judicial procedure for the commitment of an adult?

A. Yes.

Q. Have you ever testified in that kind of proceeding?

A. Yes.

Q. Now, at that proceeding you heard testimony, didn't you, from possibly conflicting sources about what kinds of behavior the person engaged in; isn't that right?

A. (No response.)

Q. You have to say "Yes" or "No" so the court reporter can hear you.

A. Yes.

Q. And in your psychiatric practice you also hear conflicting versions of the facts; isn't that right?

A. Right.

Q. Now, in that judicial proceeding for the commitment of an adult, it is true, isn't it, that it is the Court that decides on the conflicting facts?

A. Yes. That is what the commitment is about and is based on the evidence.

Q. It is based on the evidence?

A. Of the diagnostic appraisal.

Q. And the conflicting facts?

(56) A. And the complaints.

Q. Now, can you explain the reason that the commitment shouldn't also be about the same thing for juveniles? Why shouldn't there be a situation where the con-

flicting facts are given to the Court and the diagnostic appraisal of the psychiatrist is given to the Court and then the Court decides what needs to be done?

A. Why shouldn't there be commitment?

MR. ROTH: Objection on the basis—are you dealing with the same thing that we have been discussing before in terms of a judicial proceeding prior to commitment?

MR. FERLEGER: The question speaks for itself.

MR. ROTH: In order for Dr. Sugar to be perfectly clear on exactly what he is being asked, one of the things you are seeking is a judicial hearing prior to commitment. We don't want to mislead the doctor in not thinking that that is not exactly what you are asking, if that is what you are asking of him.

MR. FERLEGER: I asked the question and the doctor can answer the question.

MR. ROTH: But the question is not clear in my mind in the sense of your saying that evidence should be presented to the Court prior to commitment in order for the Court to make a decision; is that correct?

MR. FERLEGER: You spoke, Mr. Roth, before the (57) doctor had a chance to explain whether the question was clear in his mind.

THE WITNESS: I said it wasn't when I asked to have it repeated.

MR. FERLEGER: (To the reporter) Would you read the question back?

(Whereupon the pending question was read back by the court reporter.)

BY MR. FERLEGER:

Q. Did you hear the court reporter read back the question?

A. Yes.

I still don't understand what your point is.

Q. What is the reason for the juvenile who can't have the same procedure that you just described having been a participant in whereby the conflicting evidence is presented to the Court and the medical diagnosis is presented to the Court and then, as you have testified, the Court makes the decision about what needs to be done in a non-emergency situation?

A. Well, with the adult there is usually no one in loco parentis, except the Courts, and the law, and this is supposedly there to protect and safeguard the individual as well as society.

With the child you have the safeguard by parents, and since both parents function fairly suitably in that role, they are not going to want to incarcerate a child unless there is some specific need for it based on somebody's evaluating it (58) and having it then taken care of professionally; but if the procedure that you are suggesting be done, then I would see perhaps a nice increase statistically. I don't mean nice in terms of benefit. There would be quite a considerable increase, I would think, in terms of more crimes and more violence and more suicides and more other violent acts. There would be longer waiting lists to see psychiatrists, and it would be quite deleterious to the youngsters.

Q. Because you mean it is easier to get youngsters into treatment under a non-judicial procedure?

A. I am pointing out that there would be less delay in getting them help since the parents are assessing the child's needs rather than having someone evaluate and then somebody start some treatment procedures.

Q. When you talk about longer waiting lists and more crimes and all that sort of thing, under a judicial procedure, are you saying that judges are less likely—that the judges are likely to commit a smaller percentage of people than doctors would commit?

A. I am not talking about the percentages of commitments. I am talking about the delay in doing something needed for the child.

Q. But you have that delay, don't you, with adults as well and adults are capable of committing as serious crimes and disturbing behavior as juveniles, correct?

(59) A. Usually, in that case if a child—if the adult is in some way causing difficulties he is usually under the protection of the law.

Q. What do you mean "protection of the law"?

A. Well, he is usually safeguarded by the police, isn't he, or some other situation, or he is under a peace bond by the family to keep him in some kind of state where he is looked at.

Q. It is your information that there is no such procedures available for juveniles?

A. My point is not that there is no such procedure. My point is that you are impeding the pursuit of treatment and the delay would lead to more difficulties if the institutionalization isn't done when it is needed.

Q. But your testimony is for adults the way we get around that problem is by having peace bonds and other protections of the law?

A. You can put an adult in jail if you need to. Where would you put a child?

Q. In a juvenile institution.

A. There is a question of how suitable it is for the job.

Q. Isn't there a question as to the psychiatric institution for children?

A. Yes. It is a different sort of evaluation and a different sort of structure.

Q. Isn't there a question of how suitable jails are for (60) mentally ill adults?

A. Yes.

Q. So then, what are the alternatives for the adults? There is a delay for children and there is a delay for adults, isn't there, and they are both not very good for a psychotic's mental health?

A. Part of the delay with the adults is that society, I gather, is acting in loco parentis. Someone is taking the responsibility to do something to look after this person's interest whereas the child, the parents are looking after the incompletely, undeveloped person and his needs and they are looking after him.

Q. But you testified earlier for the child—it can be the police or the school or some other person besides the parents.

A. Yes, who first notices the behavior and brings it to someone's attention.

Q. Who looks after the interest of the child?

A. In loco parentis, if it isn't an emergency situation—

Q. Well, in the non-emergency situation—I still don't understand why we don't have the same problems for adults. We have the delay. We have the jails that you

testified are not very good for mentally ill adult problems.

Why should we have judicial procedures before an adult commitment?

MR. ROTH: I object on the basis that the question now is becoming argumentative and the doctor has responded (61) several times to it in connection with the development of the adolescent, et cetera, et cetera.

I think he responded at least three or four times, which the record will reveal.

BY MR. FERLEGER:

Q. In terms of the adult, do you feel psychiatrically that there is a need for a prior, judicial hearing before a commitment?

A. I presume I was here to discuss adolescents.

Q. And also differences between adolescents and children.

A. And their needs which, I think, I have answered.

Q. Can you answer my question? If you feel unable to answer, you can state that, but can you explain to me whether or not psychiatrically there is a need for judicial hearings before commitment of adults?

MR. ROTH: Is that before the voluntary admission by an adult of himself or before an involuntary commitment?

MR. FERLEGER: For an involuntary commitment.

THE WITNESS: If the person objects to being in there, whether he is delusional or not, if he calls counsel to look after that interest of his, then for

the sake of the law and the patient's understanding that he is in need of being there, not just because of psychiatric testimony, then this supports his need to be in the institution.

BY MR. FERLEGER:

Q. Dr. Sugar, isn't it true that a judicial proceeding can (62) also be traumatic for a juvenile delinquent who is in Juvenile Court?

A. Yes.

Q. And it is true that a proceeding which is a judicial proceeding can be traumatic for an adult as well?

A. Yes.

Q. An adult mentally ill or not mentally ill?

A. Yes.

Q. Lots of people get anxious and upset before appearing in court even for a traffic violation.

A. Yes.

Q. Now, you testified that you are familiar with the Gault Decision which requires hearings for juveniles in Juvenile Court when that procedure is for their rehabilitation.

Can you explain why the trauma of that hearing for that juvenile delinquent isn't enough to make it, in your psychiatric opinion, inadvisable to have a hearing?

A. At that point we have to establish if there is a psychiatric condition which needs immediate attention.

Q. Assuming we have one of those juveniles who is a juvenile delinquent or at least an accused one who has, as you testified many of them do, an emotional problem—

A. Yes.

Q. —would you, in that case, if a judge called you up, would you advise the judge not to have a hearing because it (63) might be too traumatic for the kid?

A. Not without my evaluating. I couldn't make that statement.

Q. If you had evaluated?

A. If I had evaluated him and I had come to that conclusion, yes, I would tell the judge what I thought, and if that was my opinion, I would render it.

Q. So you can conceive of a situation where it would be your medical opinion that the best interest of a possibly, emotional, disturbed juvenile delinquent where his best interests would not be served by having a hearing; is that right?

A. Right.

Q. Now, Dr. Sugar, you testified that commitment is sometimes appropriate for a number of classes of juveniles, and one of the situations you described in these words was "Some people don't fit into the family scheme."

Now, can you explain exactly what you mean by that?

A. Yes.

I was referring to someone who is psychotic and bizarre in their behavior and having delusions, persecutions, and they feel that everybody in the family is poisoning them or out to hurt them or people—or people in the family trying to accommodate to that. They have further accusations and threats made against them, and they are under constant strain because they feel the person is going to follow through on some of the threats they have made and in response to what they feel (64) are all sorts of perfidious deeds.

Q. For juveniles who have less serious problems, isn't it true that there may be situations where foster care or temporary care with a relative or some group, home-type situation where some treatment, alternative or living alternative—or some institutionalization might be appropriate?

A. Yes, that is sort of a form of institutionalization.

You are removing them away from the home which is sometimes treatment in and of itself. You are putting them in a foster care situation which sometimes is very useful treatment.

Q. In your opinion, should that decision be made by the Court or by a psychiatrist or by both?

A. I think it should be a psychiatrist's opinion in terms of the youngster's emotional needs and in terms of what this might potentially benefit him with by placing him in that kind of an institutional setting.

Q. Now, when a parent neglects a child or doesn't give the child enough to eat or, you know, someway is in a gross way not responsive to the needs of the child, and the child needs that kind of alternative placement, is it your opinion that that decision should be made by a Court or by a psychiatrist or by both?

A. Well, in that kind of situation, we are not talking necessarily of a psychiatric condition. We are talking about ordinary needs not being met, and the law or the family doctor (65) should be the responsible one for that.

Q. The law or—

A. We are not talking about a psychiatric condition there.

Q. That's right.

Who should make the decision?

A. Well, it is a legal question ultimately. It is obviously a legal question.

The doctor can initiate this, which is, for instance, what happens with child abuse cases.

Q. So your standard seems to be then when it is a medical or psychiatric question that the Courts shouldn't be involved?

A. No.

Q. But when it is a legal problem—

A. If it is a legal problem the Court should be involved to implement what is necessary for the law to implement and what is needed for the youngster just as I said in the child abuse cases. The pediatricians are the first ones to make the diagnosis and to bring attention to this. They are the ones that call the law. The law follows through on the diagnosis and places the child elsewhere for its own protection.

I am really not saying what you just intimated. I was saying that they can work harmoniously together, just as I mentioned.

Q. Now, in the case of a child who is, let's say, five years old, six years old, seven years old, do you feel that a child of (66) that age is mature enough to decide whether or not he or she wants to be institutionalized?

A. No.

Q. Now, in a situation where a parent might feel and perhaps a psychiatrist might feel that institutionalization is appropriate do you feel that the decision of the parent and the psychiatrists ought to be enough to effect institutionalization without the Court's interference?

A. Yes.

Q. You don't feel that there is any necessity for someone to be appointed to represent the interest of the child separate from the parents?

A. No.

What you are suggesting, if that is done, is that there is no need for the medical profession; that the medical profession's diagnosis and recommendations are not of any value.

Q. Well, it's true, isn't it, that just as when we have a hearing in this case, we will have experts, medical experts on both sides say that if someone who is interested in representing the child's interest separate from the parent's chosen psychiatrists, that we could have medical opinions on the other side of the point?

A. You may.

Q. And when there is that conflicting medical opinion, who do you think should make the decision?

(67) A. Well, I feel in many cases the conflicting medical opinion is either resolved by the parents, if it is a legal case, and if it is the responsibility of the judge, then the judge takes that into consideration.

Q. Well, this whole suit is about whether it should be a legal case.

If we have a situation where we have conflicting medical opinions about whether a five-year old ought to be institutionalized, is it your opinion that the parents ought to make that choice or that a Court ought to make that choice?

A. Why would it be a court case in the first place at age five?

Q. That is what the lawsuit is all about.

The plaintiffs' position is that the parents shouldn't be allowed to make that decision without it being a court case.

The defendants' opinion is that it should be.

You are the expert, and I want to know what your opinion is.

A. My opinion has been—

Q. That it should not be a court case; is that right?

A. Unless there is reason for it to be a court case.

Like, a criminal action or something that brings it—

Q. Without a criminal action when the child—

(68) A. I don't see the need for a court case.

Q. You think that the parents should be the ones to make that decision?

A. The parents are the ones who bring the complaint. The doctors are the ones you bring the child to.

Whether he is five or 15, the doctor is the one that makes the assessment.

Q. And the parents should be the ones to make the decision about institutionalization?

A. The doctor makes the decision. The parents follow through.

Q. If there is conflicting—

A. Then they can get a third person.

Q. And if there are ten opinions—

A. Then it is their ultimate choice, unless there is a legal condition such as a criminal act.

Q. If it is the parents' ultimate choice, what do we do in a situation in which you have testified to, where the parents have their own problems and are not in a position to make that choice?

A. Well, fortunately, those don't happen that frequently.

Q. When they do happen, we could have a situation where the parents are making a choice and it is not in the best interest of the child, couldn't we?

A. Well, if the child is in an institution, we presume that the people there are trained physicians; trained to do the proper (69) job, and that the child, if he doesn't belong there, they will do something appropriate about that. Otherwise, we get in a position ultimately according to what you are suggesting of having it like in Russia where the judges decide for political reasons that someone has a psychiatric condition.

Q. I don't understand why my five-year old suddenly is a political prisoner.

A. I am just extending your argument; that the doctors and the parents don't have the responsibility, and the State has the ultimate choice about matters that ordinarily are parental responsibilities.

Q. You did testify on direct examination, Doctor, that the dumping into mental institutions which Chief Justice Burger is concerned about has happened and the parents do abuse children.

A. It does happen, unfortunately, yes.

Q. And very often that happens with the cooperation of the psychiatrist; isn't that right?

A. It may be happening, but I think that the frequency of this happening—I would think that has been overstated by your comment.

Q. By what?

A. It has been overstated by your comments.

Q. Now, I would like you to explain, Doctor, your comment earlier when you testified, and I think these are your words, "That the point of having a hearing is mixed up with (70) sentimentality."

A. Well, yes.

You are saying that a five-year old should have the right to say I want a hearing.

Q. No, I am not saying that.

A. That was the case you were just talking about hypothetically, about the five-year old.

Q. I asked you whether or not a child had the maturity—

A. No, he doesn't.

Q. —to ask for a hearing.

A. No.

Q. I did not state my opinion on that.

Can you please explain your comment that the point of having a hearing for children 18 and under—that is the age range we are talking about which is mixed up with sentimentality.

A. You are assuming that an 18-year old, in spite of the points of developmental situations being incomplete, has the capacity to completely understand his condition when he is emotionally ill, needing hospitalization or when he is retarded intellectually and has an I.Q. of 50, and you are assuming, according to that, that the parents have no intelligence and no adult development, although apparently, they must have to arrive at that point in life.

Q. That is your definition of sentimentality to you?

A. I am not giving you my definition. I am pointing out that (71) there is an erroneous assumption that doesn't jibe with the facts; that the child's development, according to what is being proposed is complete. We know it is not. This also indicates that there is a question about the parents' abilities and responsibilities which is always deficient, which it is not.

Q. Well, can you answer my question now? You said the point of having a hearing is mixed up with sentimentality. Can you explain?

A. Yes. I am saying that everybody, according to this notion, is being put into a procrustean bed rather than a bed used for their development, their state of needs and the diagnosis.

The idea of everyone having a judicial hearing—it might be very nice, but it is really, I think, unnecessary in the vast majority of the situations.

Q. Well, that is also true, isn't it, for the various capabilities and intellectual and emotional levels of adults

as well? Don't we have the same procrustean bed where adults might be mere psychotic or might have absolutely no insight into their condition where all these adults are being given by the law? Don't we have the same psychiatric problem there?

A. I don't understand what you are saying.

What you correlate—since I said the parents take the responsibility; since their incomplete development is still their responsibility—

Q. But the law does not allow the parents of a 20 or 30-year (72) old child to take the responsibility when that 20 or 30-year old child is not able to take care of himself or herself?

A. I am afraid I don't know what you are asking.

Q. When you have a situation where a 25-year old woman is behaving in a bizarre way, let's assume she is living at home with her parents; where this adult woman is acting in a way which may be detrimental to her; where she may have absolutely no insight into what a psychiatrist would call her need for treatment, do you feel that her parents, acting in loco parentis ought to be allowed to decide on commitment?

A. Yes. That is just like for any adult. You have loco parentis in lieu of society at-large. Someone takes the responsibility. Someone like the policeman on the corner takes the responsibility.

You see someone doing something bizarre. He has his duty to perform of taking that person off the street for their protection and for society's protection.

Q. So those parents of the 20 or 30-year old, you feel they ought to be in the representation of society and it is your duty to be able to institutionalize their child?

A. In the usual procedure of having someone evaluate and assess what is going on, which is what is done—

Q. With or without a Court making the decision?

A. If the person agrees to it, then there wouldn't be a need.

Q. If the person has no insight at all?

(73) A. If the person has no insight and has a delusion that they're being persecuted and they want to have a lawyer come in and the lawyer says "You don't have a persecution complex; you are not psychotic and I will defend you in court—"

Q. Suppose there is no delusion of persecution. Suppose that the parents feel the child needs psychiatric help.

A. Yes.

Q. Suppose they invite a psychiatrist to come over for tea and the psychiatrist makes an evaluation and agrees, do you feel that the Court should be involved or should that psychiatrist's evaluation be sufficient?

A. The psychiatrist's evaluation should be sufficient.

Q. Dr. Sugar, how many articles which you have written have been published?

A. Approximately 35.

Q. How many of those articles deal with children?

A. I don't know.

Q. Do you have a list of your articles with you?

A. No.

Q. Do any of those articles deal with the law and psychiatry?

A. No.

Q. Have you had occasion to study questions involved in forensic psychiatry?

A. Not specifically in great depth. I have studied some.

Q. Just to clarify one further thing: When you stated earlier (74) "Due process is available in due time," you were not purporting to give us your legal opinion about what due process is, were you?

A. I was quoting what I heard here in terms of the law, allowing a hearing to be held in a certain number of days after institutionalization if the person chose to institute themselves.

Q. Now, suppose we have that hearing which is held after institutionalization and suppose the Court at that time finds that institutionalization is not proper and was not necessary; isn't it correct that that uninstituted institutionalization could have a bad or detrimental, psychological effect on a child?

A. Yes, it could have an upsetting effect.

Q. Now, Dr. Sugar, there is a law pending in the Pennsylvania Legislature which would change the age at which children could voluntarily admit themselves from 18 to 14. It would thus allow children between 14 and 18 to go in and out of mental hospitals of their own volition, and it would require parents to go to court prior to any commitment for 14, 15, 16, 17 or 18-year olds.

Based on your testimony here today, I would understand that you would be opposed to that kind of statute; is that right?

A. I don't understand what you are saying about the parents going to court.

Q. The law would require that only children under 14—the parents—strike that.

(75) For children 14 and over, for any kind of involuntary commitment, there would have to be a court procedure.

From your testimony about the problems of adolescence, I would understand that you would be opposed to that kind of statute?

MR. ROTH: It is not a law.

THE WITNESS: It is a current proposal?

MR. ROTH: It is a current proposal.

THE WITNESS: Well, I would like to see the law in its details before I could answer that appropriately.

BY MR. FERLEGER:

Q. Well, based on what I said—

A. Based on what you said, I would think that if a youngster says to a professional "I am upset, disturbed," et cetera, "I want to be hospitalized," and he presents himself at a psychiatric institution, he would not be admitted until he has been assessed.

Q. I understand that.

A. So then if he had been admitted and does need help, I would assume that they could keep him there since he wants to be admitted and he has a condition that needs attention medically, and the parents could be contacted then. Hopefully, they would agree with this.

Q. Now, where the child does not want to be institutionalized under this proposal that we are discussing, the parents would have to go to court for children 14, 15, 16, 17 and 18.

(76) Now, I understand that you would oppose such a procedure; is that right?

A. That's the thing that we are discussing here.

Q. Right.

A. Yes.

Q. Dr. Sugar, you testified earlier that you are being paid for your testimony here today. How much are you being paid?

A. $60 per hour.

Q. Does that include any preparation time?

A. Yes.

Q. How many hours have you spent in preparation?

A. I have not totaled it yet.

Q. Approximately?

A. Approximately two or three hours.

Q. Dr. Sugar, you testified that institutionalization can sometimes provide a comfort to the child, although the child may say he hates it. Are you familiar with any mental institutions in which a feeling of hatred or discomfort at the conditions there would be appropriate?

A. Yes. There have been a number of those described wherein some of the conditions were lax and there was some difficulty in maintaining some of the things required for the patient.

Q. So, if a child objected to being in an institution like that, there would be cases in which you would agree that the child's objection is correct?

(77) A. Yes; that he should be transferred to another suitable place.

Q. Now, Dr. Sugar, I have been told numerous times by psychiatrists that it is very difficult and sometimes impossible to treat patients who don't wish to be treated; that therapeutic results can be substantially improved through the use of—they can be substantially improved when the patient is voluntary and agreeable rather than involuntary and disagreeable; is that correct?

A. That holds for out-patient care, but for the in-patient, it is a different situation because they can be tak-

ing medication, which the staff can see to it that they get, whereas on an out-patient basis, there isn't that kind of control, and if there isn't cooperation from the patient, then the therapeutic effect may come to less than optimum.

Q. Isn't it correct that the medication which in-patients get helps get the patient to the point where other forms of treatment, you know, towards a possible cure or alleviation can begin? Isn't it true that the drugs are not, you know, any sort of cure—

A. Well, they have helped substantially, and many patients when admitted to the hospital are given doses of tranquillizers and they might get shock treatments, and in spite of the treatment—he might get over a great psychotic depression and get over it quite well despite their objection. They do get benefits and, many patients do get [illegible] of tranquillizers on a graduated (78) basis so they may leave the hospital. They are functioning better at that time. They know the severity of their illness and they can go back into society.

Q. Take the situation where a patient objects to the shock treatments which you have just mentioned.

A. Yes.

Q. Do you believe it should be the doctor's decision as to whether or not—

A. Yes.

Q. And not the Court—

A. That's right.

Q. How about procedures of an amygdalotomy?

A. That's your term.

Q. Or a cinculotomy?

Should those procedures be done based on a decision by a doctor or by a Court?

A. I think we are getting into the surgical field, aren't we?

I would suggest that as of the present time those procedures are still not quite far enough down the road. They are still experimental.

Q. Shock treatment you feel is a proven efficacy.

A. Yes.

It is the same question you are asking me whether the Court should approve on a million units of penicillin to be given—

(79) Q. What?

A. You are asking me the same kind of question if the Court—if a luetic should be given one million units of penicillin.

Q. That was the comment with reference to shock treatment?

A. Yes.

Q. It is your position then that whether a patient is voluntary or involuntary and an in-patient that that distinction of voluntary versus involuntary doesn't matter in terms of the kind of treatment that can be done?

A. It is preferable if he is cooperative because then you have a cooperative part of the patient to deal with, and it is easier to get on with the work, but there is resistance that has to be dealt with in terms of the opposition to it, and then it has to be dealt with. That's part of the problem also.

Q. Is it part of the treatment for an involuntary—

A. To cooperate?

Q. To be incarcerated?

A. To want to cooperate in terms of his own treatment.

Q. And that would mean to cease objecting to being institutionalized?

A. Not necessarily to cease objecting. He may continue to object, but as long as he cooperates in his own treatment, in spite of the objections, under the circumstances, just like patients may gripe about going to see the psychiatrist in his office, but they still come and they still talk about their (80) conflicts. They still gripe.

Q. In that situation the patient has a choice not to come.

A. Yes; because his functioning is such that he can get along without being institutionalized.

Q. You testified that the people with emotional problems may have trouble deciding or may have conflicts about whether or not to institutionalize themselves; is that correct?

A. Yes.

Q. It is true for adolescents as well as for adults, isn't it?

A. Yes.

Q. Both adolescents and adults—for example, your evaluation of them may make the incorrect choice as to what is medically appropriate; isn't that correct?

A. Yes.

Q. And you understand, don't you, that in Pennsylvania for an adult who makes that incorrect choice, in a non-emergency situation, the only alternative would be a judicial hearing, while if it was a juvenile, the commitment could be made without a judicial hearing?

A. Yes.

Q. Now, Dr. Sugar, you testified that when some social control agency—you mentioned the family or the police or the school, does something to help a child with

some problems that the child may be having, that the kid very often feels a relief; is that right?

(81) A. Yes.

Q. Would you include the Court within those social agencies?

A. It may at times, yes.

Q. Now, let me give you a situation and ask your opinion on it.

Where a child is accused of doing certain things or exhibiting certain bizarre behavior, and the child has a chance to have a lawyer representing him or her, or the child has a chance to give the child's side of the story, and where an independent person, a judge, who the child hasn't met before and has no previous involvement in the case is the one to decide, don't you think that in a situation where the child is not agreed to treatment that the child will feel treated more fairly and have more of a sense of the justice of the situation than in the alternative of the situation where a parent and a doctor get together?

A. Not necessarily, no.

Q. Will you explain.

A. You are dealing with a hypothetical situation, and we don't know what the dynamics are. We don't know what led into the behavior used as a basis for the diagnosis and for admission.

We are talking generally about a point of representing someone's interest and not getting treatment. We are not talking about the need for treatment, the basis for the diagnosis, the basis for a medical opinion being rendered, so just because a lawyer or a judge then say you're really needing (82) admission after the judicial hearing, that doesn't mean that the youngster really is going to be more pleased about it than he was before. Some youngsters are

quite antagonistic to any authority. Some youngsters might be quite manipulative. They will do anything to avoid something that looks onto them as disfavor.

Just because the judge says it, that doesn't mean it will be agreeable or acceptable.

As we know, many of the involuntary admissions for adults, even though they have been adjudicated, the adults still object, still raise holy hell. They still want to get out.

That doesn't mean because the judge says it that a guy is going to be pleased about it.

Q. All right.

But in a situation where an adult has been committed by a Court and objects, the adult has the right to appeal in that situation?

A. We are talking about his accepting it.

I am pointing out that he may not accept it any more because a judge has said so than because his parent or because the doctor has said so.

Q. Do you think for the adults that there is not in general more of an acceptance in a situation where the law would allow commitment for any judicial hearing whatsoever?

A. I don't think there is any way I can answer that question. (83) I would say there is no way to make any kind of statement about that.

MR. FERLEGER: No further questions.

MR. ROTH: I have a few on redirect.

BY MR. ROTH:

Q. Doctor, in order to clarify what I consider to be misleading statements made by opposing counsel in connection with your examination, first of all, with regard to

the purpose of the lawsuit, you have been advised of the two sections that are in question, the voluntary commitment sections which address both juveniles and adults; is that not correct?

A. Yes.

Q. And have you not been advised that plaintiffs are seeking either to have juveniles treated similarly to adults in that juveniles will be allowed to admit or release themselves like adults, or, secondly, in the alternative, if that could not be afforded, that a juvenile would be given a judicial proceeding prior to commitment wherein an attorney would be representing the juvenile and explaining the condition of the juvenile to, if you will, question the validity of the psychiatric evaluation made by other psychiatrists and ultimately determining whether or not the child should be institutionalized? Is that not your understanding?

A. Yes.

Q. Okay.

(84) Now with regard to the procedure in Pennsylvania and the additional regulations, and I'm sure you have read the regulations, have you not?

A. Yes.

Q. Just in looking at the additional regulations which is Annex A, I don't think we need to introduce this as an exhibit. However, it is the additional regulation adopted by the Department of Public Welfare on September 1, 1973.

Could you just read that first paragraph on how juveniles are referred.

A. "All juveniles of aged 18 and younger, to be admitted to institutions must be referred from a recognized medical facility, mental health, mental retardation thera-

pist or mental health agency. However, mentally retarded juveniles may be referred by either a pediatrician or general physician or a psychologist."

Q. Doctor, in terms of a juvenile coming to the doorstep of an institution, it is not as if a parent brings a juvenile and says "Look, I want my child committed or admitted." However, he has to undergo numerous safeguards; is that not correct?

A. Yes.

Q. And then under the Act itself, which you are familiar with in terms of Section 402 and 403, it states, which I would request you to read, and we are referring to Section 402 of the Mental Health and Mental Retardation Act of 1966—would you read that, please.

(85) A. "When an application is made, the Director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted."

Q. So, then we do have an additional psychiatric evaluation being done of the patient.

Now, according to your understanding, would you feel that those are appropriate safeguards?

A. Yes.

Q. Now, there has been—

MR. FERLEGER: I just want to note for the record that there is no indication in the regulations that the referring examination cannot be one and the same as the examination that is made under Section 402 (b).

MR. ROTH: Well, the only way you can get to the institution is by the referral or recognized medical facility.

Supreme Court, U. S.
FILED
AUG 2 1978
MICHAEL RODAK, JR., CLERK

VOLUME II—Pages 435a-865a
APPENDIX

In the Supreme Court of the United States

October Term, 1978
No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

APPEAL DOCKETED MAY 31, 1978
JURISDICTION NOTED JUNE 19, 1978

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MR. FERLEGER: There is no indication that the Director cannot then have the examination under 402 (b) or the examination done by the referring facility.

A. I would think that quite unlikely in view of the wording of this.

BY MR. ROTH:

Q. Doctor, Mr. Ferleger questioned you whether or not you have any objection to the Court working harmoniously with the psychiatrist, and then he sort of led you down the primrose path (86) of questioning whether or not facts should be presumed to the Court.

In essence, viewing the purpose of this lawsuit and knowing full well what is sought in the way of relief, I am questioning whether you feel that juveniles should be allowed to admit and release themselves at will as adults are?

A. No.

Q. And could you—I'm sorry if we have to be repetitive. We just have to clarify this.

Could you indicate why?

A. For the reasons of the incomplete emotional, intellectual, physical, hormonal things that the adolescent has not achieved yet and that he is under the care and responsibility of the parents, and the parents are the responsible parties. So, if a youngster feels so threatened, so disturbed that he feels he wants to be admitted and somehow he hasn't gotten the message across to his parents and he presents himself for admission at a psychiatric facility and the proper examination is done, and the diagnosis is made indicating he needs admission, then in that case the admission could be followed through with parental approval. If not, then approval of the law would be sought.

In other words, if a youngster needs to be admitted because he is a threat to himself and society and the parents say no, then the physician has a choice of contacting the law and saying make a judicial hearing to admit in spite of the (87) parents' objection.

Q. That goes along with the example before if a child wanted assistance and came to you, and even though the parents did not want to institutionalize the child, and even under our current safeguards, if you will, that would not likely happen in that there would be a referral to the institution, but nonetheless, assuming a child came to the institution and was begging for help and you, in your opinion, felt that the child needed help, although you may like to institutionalize a child at that point, you would be precluded from that, according to the law, correct?

A. Right.

Q. Now, however, that would not preclude you from seeking—from petitioning the Court?

A. Yes.

Q. In order to have the guardianship of the parents relieved?

A. Yes.

Q. With regard to the determination of adults and how they are admitted involuntarily into Pennsylvania and since we have not addressed ourselves to this section because, as you say, and we discussed, we were questioning your professional opinion in connection with juveniles and the treatment of juveniles and adults, Doctor, under Civil Court commitmments in Pennsylvania, and I state under Section 406 so you have a better understanding in terms of the questions that were asked of you before "Whenever a person is believed to be mentally disabled and in need of care (88) or treatment by reason of such mental

disability, an examination of such person has been made by a physician or physicians or for any reason the examination of such person shall not be made, a petition may be presented to the Court of Common Pleas of the county in which the person resides or is afforded a medical examination or commitment to an appropriate facility for examination, observation and diagnosis."

Then it goes on to say "By whom the petition can be made which may be a guardian, friend, individual standing in loco parentis or by an executive officer or authorized agent of a governmental or recognized non-profit health and welfare organization, or any responsible person."

Now, the petition sets forth the facts upon which the petitioner bases his belief of mental disability and the efforts made to secure an examination of the person by a physician. Then, the Court, upon consideration of the petition, issues a warrant requiring that the person be brought before the Court; fixes a date for the hearing and notifies the parties in interest.

After the hearing the Court can order an immediate examination by two physicians or order the commitment of the person believed to be mentally disabled. However, that commitment will not occur for longer than 10 days and there will be a report back to the Court and another hearing will be held.

Now, that is basically the way a Civil Court commitment occurs for an involuntary, committed adult in Pennsylvania.

(89) MR. FERLEGER: Is that a question?

BY MR. ROTH:

Q. And the question which I am leading up to is do you feel that juveniles who do not wish to be institutionalized ought to be afforded the same procedures as adults?

A. No.

You are viewing the issue that someone is taking the responsibility for him which is the parents, and you are abrogating their responsibility, and you are abrogating the considered opinion of psychiatrists who have made an assessment and a diagnosis and recommendation.

Q. Now, Doctor, in connection with a juvenile who does not want to be admitted to an institution and he is objecting, as the plaintiffs are saying, well, you may render an opinion saying that the child needed this institutionalization and some other doctor may say he does not, and there should be a finder of fact and that we should go to the Court then and have a judicial proceeding. How would you resolve that type of conflict?

A. I'm afraid I missed the first or the second part.

Q. If you feel that you have seen a child and the parents have explained the history, et cetera and you feel that the child warrants institutionalization—

A. Yes.

Q. —and the child is objecting and another psychiatrist evaluates the child, my question is whether or not the child (90) needs institutionalization at that point, what would you feel ought to be done at that point? Do you feel that it is necessary then to go before the Court as the plaintiffs would like to do, or do you feel that any other avenue could be resolved?

A. Well, there may be a different slant.

The second psychiatrist got from some bit of data that was admitted or that was not stressed or brought insignificantly in the first evaluation. So, if there is some kind of difference of opinion it might be useful for the two psychiatrists to come together to discuss what they feel and have a conference about it to see where they differ, or it

might be useful to have a third psychiatrist assess the two situations and evaluate the child and see what he thinks about it because there can be a difference of opinion. There are differences in theory and differences in approach in various situations.

So, if the parents are interested in handling the patient suitably they will have that further evaluation and check it out and have an opinion rendered that assesses all the possible facts.

Q. In other words, you feel that it can be handled by the psychiatrists?

A. Yes.

Psychiatrists can call for consultation or the parents can call for consultations of another person.

Q. Doctor, in connection with the harmonious working together (91) of the Court and psychiatrists, it is my understanding now that you feel the Court can come into play after the commitment. However, it is imperative that in order to preclude any delay of treatment of the juvenile, and it is based upon his chronological age which is imperative and indicative of his developmental state, et cetera, et cetera, that it is necessary to render treatment as quickly as possible; is that not correct?

A. Yes.

Q. And then if a judicial proceeding were to occur it would occur after admission; is that correct?

A. Yes.

Q. Assuming that children were allowed to admit and release themselves, would you find a lot of children who would engage in the use of drugs to be institutionalizing themselves on a Friday night late and then asking out early Saturday morning? Do you think that would occur?

A. Yes, unfortunately.

It might again be sort of a parody of utilizing the youngster to be his own physician instead of the physician making an assessment for which they are trained to do and do what is needed for the youngster because if he just admits himself and he says I want to go out tomorrow without an assessment, what has been accomplished?

Also where is the parents' responsibility? Are they being allowed responsibility for looking after the best interests (92) of their child since we assume in this society that the parents are interested in their children and look after their interests to the best of their ability?

If the youngster said "I want to go in the hospital tonight," it might be because he is afraid of coming home to see his parents which doesn't mean that he shouldn't be afraid. It means that the hospital may not be the place for him or the hospital might be the place for him. If it is, he should not be allowed to go out the next day and consider that what he went in there for 12 hours before is all suddenly vanished.

Q. Would you feel that juveniles whether admitted to State institutions or general hospitals, ought to be given hearings prior thereto if a child has, for example, an appendectomy to be performed and the parents want to place his child in a general hospital for the appendectomy, but the child refutes that? Do you think a hearing should be set up beforehand?

A. No.

Q. Why not?

A. Well, you might end up with a dead child or a child who has a ruptured gangrenous appendix or peritonitis instead of saving his life and avoiding the morbidity that peritonitis carries with it. You would have had the

whole thing dealt with properly in a couple of hours if the parent and the doctor were allowed to proceed, so that it would be to the child's interest and ultimate displeasure to have his wishes accepted since he (93) is not in a position to assess the fact that his pain in his abdomen is what it really is. He is not trained to assess it and he doesn't know the consequences, and the parents do have some idea about it, and the doctor makes a diagnosis saying surgery is indicated even though the youngster is frightened, which is the usual thing to be, and the usual thing is to object to it.

The needed course is what the recommendation should be in spite of the child's objection to it.

Q. Similarly then, juveniles would really be unaware of the degree of their emotional problem?

A. Just like adults, only more so.

Q. But there is enough of a distinction based on development and growth where an adult could make his own admission as is allowed by the law and released?

A. Yes, but it is still not on his own. It is still based on his feeling in his admission and psychiatrist's saying yes, you do have this condition. This diagnosis requires you to be in the hospital. This is still not the patient being his own doctor.

Q. Doctor, there has been some discussion about offspring of parents who suffer from severe emotional problems. Now, whether or not the parents have suffered or are suffering emotional problems, and based upon how a child becomes institutionalized in Pennsylvania, do you not feel that there is enough (94) of a review prior to the admission of any juvenile in order to determine whether the parent is using the child or whether or not the child actually needs institutionalization?

A. I think there is sufficient review and consideration of the total situation and proper safeguards by what the law currently has arranged.

MR. ROTH: I have no further questions.

BY MR. FERLEGER:

Q. Dr. Sugar, can you tell us what parts of the Pennsylvania Mental Health Law you became familiar with or read prior to this hearing?

A. These.

Q. All right.

Can you either indicate what they are or hand them to me, and I will indicate for the record. The papers you are holding—

MR. ROTH: Will you ask which portions of it you have?

BY MR. FERLEGER:

Q. I see you are holding the entire Mental Health Act.

Did you read the entire thing?

A. Yes, I looked through it.

Q. What other legal documents in preparation for this deposition did you read?

A. Exhibit A.

(95) Q. There are no such exhibits in the record.

A. Whatever these are.

Q. If you could either—

A. I don't know what you call these.

Q. Well, I can't see what you are talking about.

MR. ROTH: He read the results of the State Hospital Analysis.

MR. FERLEGER: I don't know what you are talking about.

MR. ROTH: The Summary Sheets.

MR. FERLEGER: The Summary Sheets to the interrogatories which were submitted to the Court in this case?

MR. ROTH: Right.

MR. FERLEGER: Okay.

MR. ROTH: This was about the new law lowering the age from 21 to 18.

MR. FERLEGER: Which was attached to an exhibit, I believe, Exhibit A.

MR. ROTH: To a Memorandum of Law which was also reviewed by him to your Complaint. This was to my answer to your Complaint, a Memorandum of Law of Sovereign immunity which was sent. This was in answer to interrogatories of the Court Order.

The additional regulations and our most recent Memorandum of Law—

(96) The last thing you referred to, the Memorandum of Law with regard—

MR. FERLEGER: That is—is it filed of record in this case?

MR. ROTH: Yes.

MR. FERLEGER: Well, the last memorandum you referred to, can you tell me what that is or let me see it instead of keeping it away from me?

MR. ROTH: Mr. Ferleger, I object to your obnoxious attitude, but I will be more than happy to give them to you.

MR. FERLEGER: May I see it?

MR. ROTH: It is a Memorandum of Law that was filed—we are trying to find a date on it. I think this may have been one of the first ones filed.

MR. FERLEGER: May I see it?

MR. ROTH: Yes.

BY MR. FERLEGER:

Q. So you have not seen any of the Memoranda of Law of the plaintiffs expressing their position; is that correct?

A. Just what I have seen.

Q. You have not seen anything with my signature at the end giving our opinion on the merits of the lawsuit, have you?

MR. ROTH: Just the Complaint.

THE WITNESS: This is what I have seen.

(97) BY MR. FERLEGER:

Q. Do you recall reading any memoranda or briefs with my signature at the end expressing our position of the plaintiffs on the merits?

A. I will look through it and see.

MR. ROTH: I object to this whole line of questioning in that it is irrelevant.

BY MR. FERLEGER:

Q. Is that also your answer, Dr. Sugar?

A. Yes.

Q. Dr. Sugar, you testified just now to Mr. Roth that juveniles shouldn't be allowed to admit and release themselves to institutions. What ages were you talking about when you used the word "juveniles" in that context?

A. The specification here being under 18.

Q. Do you believe that 19-year old adolescents ought to be allowed to admit and release themselves?

A. They are treated as adults. They have the majority. That is the law.

Q. I am not talking about the law. I am talking about their mental condition.

A. Yes. They are in a much more mature condition.

Q. Much more than the 18-year olds?

A. Yes.

Q. So, it is your psychiatric opinion that 19-year olds (98) ought to be allowed to admit and release themselves?

A. From a psychiatric evaluation.

Q. So your answer is yes?

A. It is not yes. It should be on the basis of a psychiatric evaluation.

Q. And it is your psychiatric opinion that with psychiatric evaluations 18-year olds should not be allowed to admit and release themselves?

A. Yes.

Q. I thought, Dr. Sugar, that you had testified earlier that adolescents, 15, 16, 17 or 18 ought to be allowed to admit themselves with a psychiatrist's evaluation.

A. Yes, I did. Excuse me. I had a lapse in what you were saying.

Q. What is your opinion then? Should they or shouldn't they?

A. They should be allowed to admit themselves if the psychiatrist agrees that they need admission.

Q. So then what you testified to Mr. Roth then was incorrect?

A. I testified to the same thing.

Q. Well, I believe the record will show that you testified that they should not be allowed to admit or release themselves.

A. I said they would be allowed to release themselves. I said if they need to be admitted and they present themselves at a facility and they say "I am disturbed, I want help," and the psychiatrist concurs in making the diagnosis and he suggests (99) an admission would be the best course, then they should contact the parents and then the procedures should be arranged for the youngster to be admitted.

The youngster has a right to say "I hurt," and then somebody responds. So, the psychiatrist, if he is the first one, he makes a diagnosis and then he contacts the parents or guardians and they take—

Q. Suppose the parents don't agree?

A. I took up that point earlier with Mr. Roth.

Q. What is the answer if they don't agree?

A. The physician has the choice then of contacting the law to institute proper proceedings; to admit this youngster because he is a danger to himself or others.

Q. In terms of your expert opinion on what the law should provide, the law now provides that people above the age of 18 may make applications to mental institutions. Do you feel that children between the ages of 13 and 18 ought to be allowed to make that application understanding that after the application there will be an examination?

A. I think I just answered that question.

Q. Do you feel that they should be allowed to make that application?

A. I think I just answered that question.

Q. Can you answer my question?

MR. ROTH: I object.

(100) BY MR. FERLEGER:

Q. Do you feel that children between the ages of 13 and 18 should be allowed to make application to an institution?

A. By "application," what do you mean?

Q. Under the statute that you are familiar with.

A. I want to know exactly what you are referring to when you say "make application".

I just answered the question of the youngster if he is disturbed and he presents himself at an institution or a psychiatrist's office and says "I am upset. I want to be in the hospital."

Then the psychiatrist may make an evaluation and then follow the procedure I just mentioned.

Does that answer your question?

MR. ROTH: I object to this on the basis that Dr. Sugar has already replied to the Act and indicated that parents admit their juveniles up until 18 and has indicated when you tried to question and indicate whether or not he was saying juveniles should be able to apply for admission. Dr. Sugar responded to that by saying no, that juveniles, if they need help, can seek help, but the application still goes through the parents.

I can't understand why you are harassing him with this question four or five times.

MR. FERLEGER: He has testified in both directions (101) on this question.

MR. ROTH: He has not.

MR. FERLEGER: He said himself that he misspoke.

We are talking about the word "application".

THE WITNESS: Does that clarify the fact that I do not understand what your question was and that, therefore, I corrected it?

BY MR. FERLEGER:

Q. Dr. Sugar, we are talking about Section 402 of the Mental Health Act.

The word "application" is used in that section. That section states: "Application for voluntary admission to a facility for examination, treatment and care may be made by (1) any person over 18 years of age."

For people under 18, we understand the provisions are the parents or the guardian and that they have to make the application.

MR. ROTH: Or individuals standing in loco parentis.

BY MR. FERLEGER:

Q. After the application then comes the examination.

My question is, and this has not been asked before at all: Is it your expert opinion that that application should not be allowed to be made by a person between 13 and 18 or should the person between 13 and18 be allowed to make that application?

(102) A. What does "application" cover?

Q. Application is a request to the institution to admit and/or examine.

A. I just said that he could make application.

Q. The reaso..—

A. Excuse me. I am going to have to be getting back. I would like to have some idea of where we are in terms of completing.

Q. I probably have another 20 minutes or so.

The reason that I wanted to clarify that is because the Complaint that you have read, that the plaintiffs have filed, are asking that people below the age of 18 ought to be permitted to make that application.

A. Well, if it is in the law already, how can there be a complaint?

Q. It is not in the law, and the law states that people below the age of 18 cannot make an application.

A. I see.

Q. You have testified for some people below the age of 18 that they ought to be allowed.

A. Okay.

Q. Now, Dr. Sugar, in the past year or so can you tell us how many occasions you participated in a judicial proceeding for a mental health commitment?

A. In the past year?

Q. Yes.

(103) A. I really don't know offhand.

Q. Can you estimate?

A. Very few.

Q. More than five?

A. No.

Q. In the past five years, what has been your average number?

A. I do very little hospital work. I have participated in this very little in the last few years.

Q. When was the last time, if ever, that you worked as an institutional psychiatrist?

A. I have worked in institutions and I have been a consultant to a variety of institutions, and I still am.

Q. When you state "I do very little hospital work," what do you mean by that?

A. By that I mean direct, primary care being the responsible physician for the immediate day-to-day care of the individual.

Q. When was the last time, if ever, that you had responsibility for direct, primary care in an in-patient facility?

A. Yesterday. The day before yesterday.

Q. How many days of the past year have you been involved in that?

A. Perhaps a week.

Q. So it is correct that your main experience does not involve such?

(104) A. My main recent experience involves office practice rather than hospital practice.

Q. When was the last time that your major responsibilities involved hospital practice?

A. I just told you, the day before yesterday.

Q. Has there been a period of time during which you have been involved as a hospital physician rather than an office physician?

A. I think that I'd better clarify what I am saying.

In my private practice—I at one time did a good deal of hospital work as well as office psychiatry.

In recent years I have not been doing very much hospital psychiatry. In other words, I treat my patients in

the office. If they are manageable for treatment, I treat them in the office. If not, then I refer them to someone else.

Q. You said "at one time". How long ago was that?

A. Oh, some eight years ago, I guess. Maybe 10 years ago.

Q. Now, Doctor, you testified at the end of a long question from Mr. Roth during which you read Section 406 of the Act, and you felt that those procedures would be bad for children. Those procedures required notice and a hearing and counsel and all that. Is that your opinion, Doctor?

A. If I rendered it a few minutes ago, I think that states the facts for something.

Q. And the reasons that procedure would be bad includes the trauma of a judicial proceeding and the other factors that (105) you mentioned earlier?

A. I stated my reasons earlier.

Q. Now, can you explain why those procedures should occur under the regulations which Mr. Roth referred to because those regulations, you know, require that when a juvenile objects that all these 406 procedures that you just testified are bad be followed through.

A. He was already under care of a psychiatrist and in the hospital. He is in an institution where some controls are offered and treatment is going on. He is in a safeguarded situation of a medical facility to look after him. So, when he is having a hearing, that isn't in that kind of context.

Q. The hearing in court would be before a judicial officer?

A. But he is essentially in a hospital and—the hearing may sometimes be held in the hospital.

Q. So the difference is that the juvenile is already in the hospital and at that point you feel that the Section 406 procedures are okay or at least not objectionable?

A. He is getting treatment. He has had the recommendations of admission and treatment and already started on that.

Q. How long does that usually take, those recommendations and decisions to begin treating? How long after institutionalization?

A. Well, once he is in the hospital that is part of the treatment.

(106) Removal from the home—removal from the home for any adolescent is treatment in and of itself. It takes him away from some pressures at times that they have within the family or within their neighborhood or wherever the problem may be.

Q. But hospitals also offer individualized treatment; is that correct?

A. Yes.

Q. How long after institutionalization would they typically begin?

A. I am pointing out the treatment is already under way when the individual is in the hospital.

Q. But I am talking about the additional individualized treatment.

A. I have no figure to provide for that.

Q. Usually it takes more than a couple of days, doesn't it?

A. It may be the same evening. It may be the next morning. There is no usual kind of figure that I can provide you with.

Q. Now, Doctor, you testified about this revolving door idea that if juveniles could institutionalize themselves they could sort of go in and then request to leave and then if they got out could come right back in again.

I want to check whether or not that it is still your opinion because you have now testified that juveniles should be allowed to apply for institutionalization on their own. (107) If juveniles would be, as you wish them to be, allowed to apply for their own institutionalization, would we still have this problem with them going in and out?

A. I think I clarified that point in my earlier testimony that if they do apply, they are admitted. Then they should be admitted to stay for as long as the psychiatrist needs them there.

Q. But the Pennsylvania Mental Health Act for voluntary commitment doesn't allow that, does it?

A. Possibly.

Q. You testified that you are familiar with the voluntary sections of the Act. As a matter of fact, you testified that that is the main part that you are familiar with.

A. I did not say I was an expert on Pennsylvania Law. I said I read it.

So now if you are making a point about some aspect of it, I would appreciate you clarifying what you are discussing.

Q. First let me get your position. Your position is—

MR. ROTH: Why don't you first explain it. Let me object at this point. He is being misled.

MR. FERLEGER: I will do my best to be as clear as I can.

BY MR. FERLEGER:

Q. Your position is if a juvenile is allowed to admit himself or herself that it should be for as long as the psychiatrist (108) deems necessary; is that your testimony just now?

A. Yes. It should be on the basis of a psychiatric evaluation for admission.

Q. Now, for voluntary admission in Pennsylvania, the law, for your information, provides that under Section 402 a person can leave at anytime; and under Section 403 the commitment can be for no longer than 30 days with a provision that the person can give notice and then leave after 10 days, so those provisions would not satisfy what you see the needs of juveniles to be; is that correct?

MR. ROTH: This is an incorrect interpretation.

MR. FERLEGER: We will take a minute and let the doctor read the statute.

THE WITNESS: I really am getting tired. I think there has been a lot of redundancy in the questions that I have been asked, and I would like to take a break for coffee.

MR. FERLEGER: That's fine with me.

(Whereupon, a short recess was taken at 12:12 o'clock P.M.)

(Deposition continuing at 12:24 o'clock P.M.)

BY MR. FERLEGER:

Q. Doctor, with reference to this signing in and out of institutions, I believe the last question that I asked, which was not answered, was whether it was your opinion

that the voluntary commitment provisions of the law would not be appropriate for (109) juveniles since they do not allow what you said is the right procedure for the commitment to be as long as the doctor wants.

Is it your opinion then that the Pennsylvania voluntary sections would not be appropriate for juveniles?

A. I don't know what your question is yet since the question seems to be escaping me.

Q. Let's break it down into parts.

A. You're asking me to render an opinion about law in your state, and I'm only here to render an opinion about psychiatry.

Q. I am not asking you about an opinion about law.

You stated that it was your opinion that when juveniles, let's say, between 13 and 18 sign themselves into an institution or make that application, which you are in favor of, that that should be for as long as the psychiatrist thinks it is medically necessary; is that right?

A. And you told me that is the law.

Q. Is that right?

A. I said that a youngster should be able to tell somebody he is distressed, in pain and needs to be admitted, and then if that person is a psychiatrist that person should contact the parents or the guardians to take the proper procedure for admission. If the parents object and don't want the youngster admitted and the parents refuse to cooperate and the psychiatrist feels it is necessary, then he can call on the law to act in loco parentis.

(110) Q. And beyond that it was also your testimony that a child between 13 and 18 ought to be allowed to make the decision under Section 402 and 403?

A. By "application" I meant what I just said.

MR. ROTH: I have an objection on the basis that I don't think Dr. Sugar fully understood what you meant by "application" as far as the juvenile making the application or, as he stated numerous times, that if the juvenile is in need, then he should be able, the psychiatrist, after the evaluation, he should be able to indicate to the parents or guardian that an application should be made.

I think there has been some confusion with that, and that is what we are trying to clear up.

MR. FERLEGER: Well, we read the section of the Mental Health Act defining "application" and describing it, and Dr. Sugar—

MR. ROTH: I think he has clarified that point.

MR. FERLEGER: Well, your testimony is that if the juvenile's parents agree, then the juvenile should be allowed to get himself admitted with the psychiatrist's agreement to an institution; is that correct?

MR. ROTH: I object to that. He has not said that at all.

THE WITNESS: Well, I think you are misunderstanding and you are misphrasing what I just finished saying. I have (111) said it at least six times today.

BY MR. FERLEGER:

Q. And at six different ways.

A. No, I have not. I have said it explicit each time. I think this is unnecessary.

MR. ROTH: I object.

BY MR. FERLEGER:

Q. The Mental Health Act allows application to be made for admission to an institution by any person over the age of 18; for any person under 18 that application has to be made by other people.

MR. ROTH: That is exactly what I have just finished explaining, and I think you are asking a redundant question.

I object.

You are harassing the witness.

BY MR. FERLEGER:

Q. For people under 18, should that application—can that application, in your opinion, be in the best medical sense made by the juvenile himself?

A. I think I have just answered your question.

I refuse to answer your question again. I think it is in the record. If you want to read it, fine. I don't think I need to be going over the same ground again.

Q. Now, you testified to Mr. Roth that there would be a (112) problem if juveniles could admit and ask for their own release. There would be a problem with them going in and out of the institution; is that your testimony?

A. I said that if there were no psychiatric evaluations, this is not suitable.

I just finished clarifying that a moment ago that it had to be on the basis of psychiatric evaluation, diagnosis, recommendation; not on the basis of the juvenile being his own doctor.

I think I said that explicitly just 20 minutes ago.

Q. If there is an evaluation, do you feel it would be anti-therapeutic to allow the child to request to leave

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when the psychiatrist's opinion would be that he or she should stay; is that correct?

A. Yes; but there is the availability of the law to have a hearing.

Q. Don't we have that same anti-therapeutic effect when an adult voluntarily requests to leave and the psychiatrist is in opposition?

A. Yes. The patient still goes out quite disturbed if he is not ready to leave yet.

Q. Now, Dr. Sugar, you testified with regard to operations in medicine or surgical procedures or physical problems that the child may understand and would be frightened, but that even if the child doesn't want the procedure that it should just be up (113) to the parents and the doctor whether or not the child gets the procedure; is that your testimony?

A. That's what I said.

Q. Are you aware at all of any legal provisions or limits which make it impossible for parents and doctors acting without regard to getting permission from the Court to make it impossible for them to decide on medical operations or surgical operations for children?

A. You're asking me for a point of law.

Q. I am asking you whether or not you are familiar with any legal principle which operates to limit the right of the parents to decide with the doctor as to what operations their children should get.

A. You're talking about ethical procedures or unethical procedures?

Q. I am talking about whether or not you have heard of any such legal principles.

A. I think you'd better clarify what you are asking me about.

Q. Have you heard of any such legal principles?

A. Can you clarify that?

Q. The legal principles I am talking about are those principles which prohibit or limit the right of parents acting with doctors to decide in their sole discretion what medical or surgical procedures are performed on children.

A. Where does that apply?

(114) Q. Excuse me?

A. Where does that apply?

Q. I don't understand your question.

A. Well, I am just rephrasing it to ask you to clarify what you are asking me.

Q. It applies to the situation where there are medical or surgical procedures which are contemplated.

Are you familiar with any legal principles in that regard?

A. You're asking me for a point of law—

Q. I am—

A. —and not medicine.

Q. I am asking you whether you are familiar, whether you have heard of any of those legal principles.

A. I have heard of situations where a youngster needed a tranfusion and, because of the parents' religious feelings, they would not. They would let the child die, and the Court would step in and have the medical procedure that was designated, the approved ethical procedure.

Q. Now, in a situation where an adult is advised in a medical, surgical context where an adult has advised that he or she needs a certain procedure done, and where it is not a question of life or death, it is true, isn't it, that the parents could refuse that procedure?

A. You are talking about an adult wanting to not go ahead (115) with the procedure that has been recommended?

Q. That's correct.

A. And you're asking if he has the right to refuse?

Q. In your medical judgment, what is your opinion?

A. Yes, he has a right to refuse.

Q. Even though one or two or 20 doctors may explain that it would be best to have that?

A. He has the right to refuse.

Q. Now, if that adult is told by one or two or 20 psychiatrists that the best medical procedure would be for him to be institutionalized, is it also your opinion that he has the right to refuse?

A. That is a question where the patient may not be capable of exercising proper judgment.

If you are talking about a physical condition and the assumption is made through the inference that the patient has his proper faculties for judging the situation and he refuses, it is a different situation from the very condition that needs to be tendered to as the one that is impairing his judgment and thinking processes. Then he is not in a position to exercise proper judgment about his condition and the need for treatment for that condition. So, it is not comparable to the physical situation.

Q. Is it your position that in a situation where a doctor counsels a certain surgical or medical procedure to be performed (116) on a child and with the parent agreeing that that should be outside the scrutiny of the law?

A. In the ordinary circumstances, yes.

Q. So, for example, if a young child had a healthy kidney which his parents and the doctor felt could be transplanted to another child who needed a kidney, is it your opinion that that removal of the organ should be just between the parent and the doctor?

A. That is not the ordinary circumstance.

Q. What is your opinion?

A. I would not render an opinion. It is outside of my field and specialization. I don't do kidney transplants.

Q. Well, you have rendered opinions about other medical procedures. Why is it this one that you decide not to render an opinion on?

MR. ROTH: Objection.

He has not rendered an opinion as to medical procedures. He has rendered opinions in terms of need and emergency for a condition that so warrants it.

MR. FERLEGER: I don't understand that.

THE WITNESS: I think what you are talking about is beside the point. I do not render opinions about medical procedures.

BY MR. FERLEGER:

Q. I agree that the medical procedures are beside the point.

(117) Mr. Roth brought them up in the questioning of you.

A. I was talking about these procedures that you are talking about of a kidney transplant being done on a child without his understanding and just because the doctor said so—that is not an ordinary circumstance.

I have already clarified my point. You are asking me to go into detail about a condition which is not in my area of specialization.

Does that clarify my comment?

MR. FERLEGER: No further questions.

MR. ROTH: I have no further questions.

MR. FERLEGER: Just for the record, since I came after Mr. Roth started the deposition, because I was later than I expected to be, I have not agreed to any stipulations with regard to signing or certification or filing or objections, and reserve the right to make any objections before the testimony is introduced.

MR. ROTH: You might want to show for the record what time the deposition began and what time it stops.

MR. FERLEGER: And the fact that Mr. Roth knew that I would be late.

MR. ROTH: By ten minutes, when he was late by 35 minutes.

MR. FERLEGER: I don't know of any proceedings in (118) the rules which allow counsel to begin a deposition without the other side being present.

MR. ROTH: Well, my understanding of the rules is that you are invited to attend, and the time is set forth, and as a result, we questioned Dr. Sugar about his qualifications and history and then the questions were read back to you prior to getting into the substance of the deposition, so we feel there was no prejudice whatsoever.

(Whereupon, the deposition concluded at 12:38 o'clock P.M.)

Reported by:
Marvin Dinter
Official Court Reporter

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Dr. Max Sugar

Dated:

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al,

Plaintiff

vs.

Haverford State Hospital, et al,

Defendants

DEPOSITION OF DR. JOEL S. FEINER, M.D.
Philadelphia, Pennsylvania
August 21, 1974

Oral deposition of DR. JOEL S. FEINER, M.D., held on August 21, 1974 at the office of DAVID FERLEGER, ESQUIRE, 1315 Walnut Street, Philadelphia, Pennsylvania commencing at 2:00 p.m., before Michael H. Stephany, Approved Court Reporter.

Appearances

For the Plaintiff: David Ferleger, Esquire

For the Defendant: Barry Roth, Esquire, Room 323, Health and Welfare Building, Harrisburg, Pennsylvania 17120

(2) DR. JOEL S. FEINER, M.D., having been duly sworn, was examined and testified as follows:

Examination

BY MR. FERLEGER:

Q. Dr. Feiner, what is your occupation?

A. I am a Physician-Psychiatrist by speciality, Child Psychiatry by sub-speciality.

Q. Where are you employed?

A. I'm employed by Mott Haven Unit of the Lincoln Community Mental Health Center at the Albert Einstein College of Medicine.

Q. What city is that in?

A. Bronx, New York.

Q. Will you please tell us where you received your medical and psychiatric training?

A. After I went to college at Yale University, I received my M.D. at Albert Einstein College of Medicine. In 1964 I was a Pediatric Intern at Bronx Municipal Hospital Center, and took my residency in Child Psychiatry Fellowship at Bronx Municipal Hospital Center of the Albert Einstein College of Medicine. Completed my training in 1970.

Q. Since then have you been involved in any academic work involving Child Psychiatry or related fields?

A. Since that time, I have been both a service provider, (3) working with children and adolescents in the Lincoln Hospital, Department of Psychiatry and a faculty member of the Albert Einstein College of Medicine, currently holding the rank of Assistant Professor on a full-time academic faculty.

Through the years 1972 to 1974, I held a career teaching award recommended by the National Institute

of Mental Health. I understand that I was one of two recipients of that award from the country.

My work during these two years was to teach in the areas of community Child Psychiatry, which I proceeded to do, for a variety of personnel from medical students to psychiatrists in training, social workers, et cetera.

Q. Have you delivered any papers with regard to children or child psychiatry?

A. Yes. I delivered a number of papers concerned with adolescent phenomenon, particularly related to those phenomenon observed in the South Bronx area that I have worked. I have talked about street gangs in the South Bronx and graffiti phenomenon. I have also talked about children in the context of their schools, recently having delivered a paper at the American Ortho-Psychiatric Convention in April, 1974.

Q. Does your work involve treatment as a psychiatrist of children with emotional problems?

(4) A. Yes, it does.

Q. And also families of children with emotional problems?

A. That is correct.

MR. FERLEGER: Could this be marked as Plaintiff's Exhibit No. 1, please?

(Curriculum Vitae marked as Plaintiff's Exhibit No. 1 for identification.)

BY MR. FERLEGER:

Q. Dr. Feiner, could you identify Plaintiff's Exhibit No. 1, please?

A. Yes. That is a Curriculum Vitae which I have submitted.

Q. This is your resume?

A. My resume.

Q. And this resume includes your academic appointments and professional activities and papers and a review of your experiences?

A. That's right.

MR. FERLEGER: Will you please attach to the deposition that so we won't have to go over the rest of your qualifications?

BY MR. FERLEGER:

Q. Dr. Feiner, can you please give us a brief review of the kinds of emotional and psychiatric problems that children have (5) and then have those problems fit in with their relations with their families and other social agencies?

A. Well, the vitae is enormous, and ranges from everything from severely withdrawn and clearly psychotic children, who are virtually unable to relate to other people to the kinds of problems which we would consider to be situationally based. There are problems which result from the non-supportive nature of a particular environment, the inability of the environment and the child to mesh in a way that is conducive to the child's development. In between there are a variety of problems, various degrees of severity. What I, and any others certainly in the past five years have become extremely aware of is the relationship of a child's behavior and really his psychiatric symptoms to the entire context of that child's life. The usual context is the child's family, and what we talked about in recent years is rather than the kind of diagnostic approach where a child is diagnosed quite apart from the context of his life, and really in a kind of one-to-one interview. We are now very concerned with looking at the child from what we

might call an ecological context, taking into account all of the factors in the child's life, what that includes is recognition of the fact that children are extremely responsive to what goes on in families.

(6) Perhaps the most responsive element to the child's communication is hidden agendas, overt and covert needs of all of the members of the family, and since the early '40's we have known that parents can induce certain types of behavior in children based upon their own unconscious needs.

I guess a very simple analogy might be for the need to have a child behave in a particular way might be the need that is commonly recognized, for example for the public to go to football games or boxing matches. It is often said that this is an outlet, and it provides—it serves the need for people to funnel off some of their aggression, some of their excitement, much in the same way one might suppose that this need is ongoing, and a child is often the most easily available person to continually act out for the parents.

Another example of this would be the following—there certainly are certain families where the parents are simply not responsive to the usual kinds of—one might say good behavior or positive behavior. That behavior is simply ignored not acknowledged, and a child is not—does not receive any attention for that behavior. All of us need attention, and a good part of our life goes into ways in which we can receive attention from important people, and so a child finds ways that this attention is forthcoming, and very often that is what is (7) so-called bad behavior.

Q. Does that include behavior that in other context might give you this delinquent behavior?

A. That's right.

Q. So that a child's emotional problems or the stresses in the family situation could result in children acting in ways that might be considered delinquent or criminal as well as traditional mental health type systems?

A. Absolutely, and we might say after moralistically that bad attention is better than no attention at all.

Q. From the child's point of view?

A. From the child's point of view.

Q. Dr. Feiner, are you aware of any commission or any other psychiatric reports on the needs of children that have any conclusions that relate to the kinds of problems that you were just discussing?

A. Yes. There is, in recent years, a very important commission called the Joint-Commission on Mental Health of Children, and I have a rather extended quotation from a section of that that I would like to read. It is from the report of Task Force-2, which is "Studies of Children from Kindergarten Age through Eighth Grade." It is in the Joint-Commission on Mental Health of Children, Mental Health from infancy through adolescence published by Harper and Rowe, New York, 1973. This (8) is pages 112 and 113.

Q. But Dr. Feiner, is that report considered an important one in the field of Child Psychiatry?

A. Yes. It is an important one and one which has been widely discussed and written about in various sources.

Q. Doctor, do you have a copy of that report?

A. I don't have a copy with me.

MR. ROTH: Pardon?

THE WITNESS: I don't have a copy with me.

MR. ROTH: Where is it actually located?

THE WITNESS: It is located in any library which contains psychiatric references.

MR. ROTH: May I just register an objection on the basis of his reading it without seeing a copy of the report prior thereto?

BY MR. FERLEGER:

Q. Will you please read us the quotation that you have?

A. The quotation is as follows:

"The intervener ought to recognize the close interrelation interrelationships between the individual and his surroundings and deal with the factors that impinge upon the individual from the outside as well as from within the individual himself.

When the surroundings are not taken into account, there is, (9) for example, insufficient understanding of the social conditions of diagnosis, that is that psychiatric labels tend to stigmatize."

It goes on "All of these children are plunged from their natural environments and introduced to a different setting for a cure. If the child is treated successfully in this new environment, it is assumed that he can be sent back to his old environment to make a clean start. Unfortunately, however one could not remove psychopathology like an appendix. This traditional approach disregards the unfortunate fact that children often tend to conform to the niche in which they have been placed. A child labeled 'delinquent' may begin to consider himself a delinquent, and act accordingly. Furthermore, if the environment to which the cured child is returned has remained the same or perhaps even organized itself more firmly around old lines of interaction with the absent child seen as the only 'family problem', it seems highly unrealistic to expect the child to maintain this cure in the face of re-exposure to the elements which caused his disturbance."

Q. But Dr. Feiner, do you agree with those observations which you have just read?

A. Yes, I do.

(10) Q. And you would adopt them as your own?

A. I do try to put them into the practice of my own work.

Q. Dr. Feiner, from what you have said, I understand that there might be situations where the family's problems might result in the institutionalization of children; is that the case?

A. Absolutely.

Q. How would that happen?

A. Well, that would happen in a number of ways. The family is under stress from a number of different sources, often there are some intercurrent tragedies, such as separations, deaths, illnesses and the child, as part of that family is also under the stress. The child—everybody in the family experiences anxiety in different ways. The child's anxiety may be expressed dramatically, in which case the family, being overwhelmed to begin with, feels that their lot may be somewhat better if the child is simply out of the picture for a while. It is often very likely that under circumstances of stress, families will approach—what they consider experts, professionals of some sort or another, physicians, school personnel and so on and ask for some help, whereupon the advice that they get is that the child should be hospitalized.

They reluctantly follow that advice, feel guilty as a (11) result and the snowball effect continues as the family does not ultimately really receive help for its problems.

Q. Well, why would it be the child that would be scapegoated or institutionalized rather than another member of the family?

A. Well, the child is quite susceptible, and often it isn't the child—I mean there are many situations where the child does not go on, but the child has some intrinsic vulnerability based upon the fact the child is dependent to begin with, the child is more controllable in certain ways, the child is also often a newcomer to the setting, the last to be present in this little system, often unwanted, and un—not chosen.

There also is the important fact that children do represent for the adults a replay of their own childhood, and a re-experiencing of their own problems when they were children, so that the child is—the repository of the projected bad feelings of some parents towards their own childhood.

Q. So that the result in parent misunderstanding, the actions or feelings of the child?

A. Absolutely. Absolutely. I mean I would go on to say that this is certainly not unusual for parents to misunderstand or act in ways that are inappropriate towards their children.

Q. Well, do you feel, then that parents can be relied on to act in the best interests of their children?

(12) A. Well, I am sorry to say that the increasing statistics about child abuse and child neglect, the overworked bureaus of Child Welfare, I think speak to the point that parents do not always act in the best interests of their children.

I can recount tragic cases where that simply was not so.

Q. Now Dr. Feiner, the orientation of psychiatry that you have been discussing, has that always been the orientation of psychiatry or is that a recent change in the past 10 or 20 years?

A. Well, it is really within the past 10 years. There has been an increasing attention paid to the—what we might call the context of children's lives or the ecology of their lives, and this is so in part because we have just become technically more proficient as understanding group behavior and family behavior, and we now recognize how that behavior can be looked upon rather than isolating one element of that situation and assuming that all behavior and all symptoms are somehow self generated.

Q. Dr. Feiner, are you familiar with and have you examined the deposition in this case of Dr. Max Sugar, of Louisiana?

A. I have looked at some of it, yes.

Q. Now, not with reference to his entire deposition, but only with reference to those parts examined discussing his general (13) orientation in child psychiatry, how would you place him in terms of this change in orientation that you just discussed?

A. Well, I would say that he takes a traditional point of view, which isolates a child from the environment and discusses the child's behavior and symptomatology in very specific individual terms.

Q. By "traditional" you mean that orientation would be prior to the developments of the last 10 years?

A. Right.

I would also say, if I might that there is, in his testimony a kind of—what I would consider an inappropriate

sense that institutions can be taken for granted, that parents, schools, police and so on are institutions of good will. I wish that that were so, and maybe 20 or 30 years ago it was felt to be so in general ways.

Our experience certainly working in poverty neighborhoods is simply that these institutions cannot be taken for granted; that, as I have mentioned, parents do abuse and neglect their children and schools often do not even fulfill the mandate of teaching their students, let alone are they able to evaluate behavior.

Q. Dr. Feiner, you mentioned working in poverty neighborhoods. Now, in terms of the social class of children who are likely to (14) be institutionalized, what class would that be?

A. It very often is children of lower class—

Q. Is it correct that in terms of the various state hospital systems in the country, that it is more likely that lower class or lower middle class are patients there rather than the upper class?

A. It is my understanding that that is so, and in fact that often—the professionals who do the evaluations are at some great distance culturally, class wise and geographically from the situation in which these children are living, and misperceive behavior.

Q. Dr. Feiner, will you please tell us the general effects of institutionalization in mental institutions and especially how they may affect children?

A. Well, institutionalization is an extremely serious matter, especially mental institutionalization, extremely serious. First of all, there are no good studies, to my knowledge that really long range benefits are achieved from treatment. That, traditionally upon re-emergence into the community children are often, as I have said earlier, placed

in the same circumstances which they left, and the mental hospital has either done a sequestering of them from the real problems of their lives or an opportunity to participate (15) in some unreal world. Also the fact that problems have been dealt with by hospitalization has—is very often a first resort solution establishes mental hospitalization as an ongoing way that people should deal with their problems or that this child should deal with his problems in the future. Certainly we have to be very aware that there is a stigma that remains to mental hospitalization, and that a child at some point in his life will have to apply for licenses, have to apply for jobs, will have to account for this period of his life in some way, and we know that the reality is that the public does not look upon mental hospitalization as a benevolent benign situation.

The family is often stigmatized, and feels guilty as a result and looks, then for this person to behave in similar ways. After all, a mental patient, in our society is someone who has been in a hospital, someone who is psychotic and not in a hospital is not considered a mental patient. The operational definition of a mental patient is someone who has been in a mental hospital, and that brings with it certain expectations of the people around; moreover hospitalization sometimes obscures the kinds of permanent and environmental issues that I mentioned, it just tucks them away, and may never deal with them, and one may often get one child hospitalized (16) for family reasons, and then low and behold the family classes the next child in line in the family to start to deal with its problems.

Q. Has that happened in your experience?

A. Yes, it has happened.

Q. So that once one child in a family is institutionalized, you wouldn't be surprised, if, after a period of time,

the next child develops some problems and becomes institutionalized?

A. It has happened in my experience, when the family has not been dealt with.

Q. Dr. Feiner, it seems from your testimony, then, that you consider treatment by physicians in mental hospitals to be somehow different than treatment for physical problems of children in community or even in a general hospital such as a tonsilectomy or some disease that requires hospitalization in a regular hospital?

A. Well, I do, because if one were to bring a child with tuberculosis to a doctor—and this is really a similarity, in a way, one would test all of the people in that family for tuberculosis and treat them, if one found tuberculosis. I feel that taking a child to a psychiatrist for treatment is different in part because there are qualities of this child having a contagious disease that needs the entire situation, as I (17) mentioned previously, that needs to be looked at, and the response of the environment or of the psychiatric institution has many alternatives.

Q. Dr. Feiner, since this lawsuit involves an attempt to attain judicial hearings to explore alternatives to institutionalization and the needs for institutionalization, are there alternatives for treatment of children who need mental problems that a court could explore or is hospitalization the only possibility?

A. No. There are alternatives that I would expect ought to be used even before it gets to a court. These are by now tried and true situations.

I will refer to one of them which is a study called "The Treatment of Families in Crisis." In the results reported in this book, which is by Drs. Donald Langsley and David Kaplan, 75 patients who would normally be admitted to a hospital were matched with 75 controls, all of whom were admitted to hospitals according to usual procedure. The 75 patients who were treated in a family context with intensive rapid intervention of a variety of various ways showed 85 percent less hospitalization over 6 months than those who would have been hospitalized in the regular way. This saved all of the problems of being hospitalized and is a dramatic way of (18) relieving stress in a family and working in a problem oriented way towards the supportive and human and quite appropriate resolution of family problems.

After all, the family often comes in in panic, has—they have exhausted their own repertoire of behaviors and solutions, and often it is common in and of itself for someone to say "Calm down, I think we will be able to help, let's see what the problem is. Maybe all you need is a good night's sleep, which I can help you have, and let's talk about it and see what resources are available." This worked initially in 75 out of 75 and then over 6 months only 17 percent of those 75 had to be hospitalized.

Q. Now, is this an accepted alternative, then, without hospitalization?

A. Absolutely. It is an accepted alternative which requires a vigorous effort on the part of mental health personnel.

Q. Now doctor, the calming effect that you just described reminds me of Dr. Sugar's testimony where he testified that when a child is brought into an institution, a mental institution, there is very often a sudden, you know, relief of stress, and the child—almost says—feels good to be there. Now, is there any other explanation besides the beneifts of hospitalization that might explain that relief?

(19) A. Well, in an ironic way that in part may speak to the situational nature of the child's problems—that the child hasn't gotten any therapy yet, there hasn't been any internal reorganization of his character structure, he just has had a situational environmental manipulation, and what I am suggesting is that can be done while the child is still there with an objective parent, who is human and sensitive to the needs of this family, and I would say that calming effect could in fact be just a non-specific relief that somebody is doing something about a situation.

Q. Dr. Feiner, most often—and you can confirm or deny whether this is actually true, but it appears to me that most often psychiatrists to whom parents bring their children or parents are directed to bring their children learn of the symptoms and the background of the behavior of the children from the parents, and I wondered if you could discuss, as you have peripherally earlier, whether or not parents are reliable sources for that sort of information?

A. Well, I am not sure that anybody who is experiencing tremendous anxiety is reliable for this source of information. I think that they, too, are very much in the situation and obviously can't be objective reporters of the situation. Clearly what they have to say is important—I wouldn't deny (20) that their information is important, if not crucial; however, it is only one of the part of the whole thing. Very often we see a child, mental health professionals will see a child on one occasion and make an evaluation that really needs to be thought about, because a child is going to be either overly anxious and show behavioral manifestations or withdrawal, because of the unfamiliarity of the setting, the kinds of feelings that the child has that this interview is going to determine the child's fate for a good period of time, and there is no sense that this—that

this situation is in the child's best interest. So likely what a psychiatrist would observe is artifact, to some extent.

Q. So then the kind of brief evaluation that patient or potential patient would get, as under the state's regulations and the statute involved here, either at the hospital upon admission or by a referring agency, that kind of examination might not be the best way to really find out what is happening with this child?

A. It might not be the best way.

Q. Now doctor, there is some dispute in this case as to who should determine the facts involved in a particular child's situation. In other words if the child is accused of behaving in a certain way, if that is true, it might mean one thing to (21) a psychiatrist, and if it is not true it might mean something else. Now, do you feel that psychiatrists are social agents who are best qualified to make those kind of judgments or should it be a judicial or other sort of thing—partial agency?

A. Well, I think that when it comes to the point of determining facts for the purpose of making major and dramatic alterations in a person's life, that we need help, that we are—the facts that we are used to gathering are often the psychological facts which require some interpretation and some subsequent validation. We do not always have the access to the facts, although in some contexts, such as crisis intervention were, we try to get it by immediately making home visits, by immediately going to schools, by trying to gather as much information as quickly as we can, but we are really taught to evaluate emotional experience, which often is the person's interpretation of the outside world, and not the outside world itself.

Q. Doctor, from what you have said, and based on your professional experience, do you feel that for children

19 years of age and under that a pre-commitment hearing to determine the need for hospitalization is appropriate?

A. Well, let me say, if it comes to that, it is appropriate. (22) From my point of view it would certainly would be that there are many things to be tried first, and many ways of responding to paying, and—but if it comes to that, it certainly is appropriate.

Q. Doctor, do you feel that a requirement by the law that there be a pre-commitment hearing rather than parents being able to apply for institutionalization that that requirement would encourage psychiatrists or parents to explore those alternatives?

A. I would certainly hope that it would, that this would underscore the serious nature of hospitalization and cause people to have second thoughts, and to search out various alternatives such as one that I have mentioned earlier.

Of course there are others.

Q. Now Doctor, can you explain why, for both the children involved and for the family a judicial hearing might actually be therapeutic or beneficial?

A. Well, I think if it reaches that point, it is very likely that the child—if the child is the one that is refusing the hospitalization is feeling rather helpless and hopeless, and feeeling rather abused, and unable to turn to anyone, I would say at this point, being very crucial that the child have a Advocate to diminish the possibilities of the hopeless and (23) helpless feeling. After all, an important reason why many children set up, set out, and do whatever they do that may have caused them to get into the hospital is because they feel hopeless and helpless, and to be forced into a situation in a similar way is reinforcing this feeling. Then, if they get into the hospital in this situation,

they have been coerced, and it is extremely difficult to treat anybody who is being in treatment under all the mayhem or coercion.

Now, for parents they often are hospitalizing the child because of other people's suggestion, and ongoing support for this procedure. It may in fact be very supportive for them to submit the situation to an independent kind of evaluation, which would then relieve them somewhat of the subsequent feelings of guilt that they may have.

Q. And that independent evaluation could be the testimony of a psychiatrist before someone appointed by a court or a court and an airing of both sides of the story?

A. Yes.

Q. In the courtroom?

A. Yes.

Q. Dr. Feiner, have you read the Pennsylvania statutes that are involved in this case?

A. Yes, I have.

(24) Q. And have you read the regulations recently promulgated by the state regarding conditional safeguards for children?

A. Yes, I have.

Q. Do you have a copy of those regulations with you there?

A. Yes, I have.

Q. These regulations are the regulations that I published in the Pennsylvania Bulletin, Volume 3, number 37, page 1840 and they are part of the record of this case with reference to these regulations, which only apply in some parts to children between 13 and 18, do you—will you please comment on the appropriateness of the notice to children of those ages which are read to them. Do you feel that that notice is likely to be understood by children or misunderstood?

A. Well, I think for two reasons, essentially it is likely to be misunderstood. One it will be read to a child when there will be many other things on the child's mind—getting used to a new environment, "What am I doing here, I feel abandoned, I feel helpless—" and so on.

Secondly it is in language which is extremely difficult for an adolescent to understand. If this is to be read to children at least let it be read in such language that is attentive to their level of comprehension.

Q. Now Dr. Feiner, if a child who is admitted to an (25) institution in the manner now under the law objected under these regulations and then after a court hearing was released back home and found not in need of hospitalization, could that have any bad or negative effects on the child?

A. Yes, clearly if the parents have gone to this length, they will be resentful. They are likely to take it out on the child, who is the most immediately available scapegoat. The child will feel resentful. There has been no communication established between them, and it is likely to have a very destructive effect. I would also say that none of the other possibilities or alternatives are elaborated in this statement, so the child may simply say "I want to remain here, because this is known, I am already here," and the other alternative is "I don't know, I'm going to take the safest place for now, because I am already here."

Q. So that would be a reason that children who really do object wouldn't want to say so?

A. Yes, it would be.

Q. Now, the negative effects of getting to the hospital and then leaving after a hearing which results in a finding in favor of the child, is it your opinion that that

would be a reason to have the hearing prior to the commitment?

A. I think that there is good reason for having it prior, (26) so that other alternatives can be looked upon without having any more steps interposed.

Q. Dr. Feiner, for children under 13, do you feel there is any need or reason to have an Advocate or some procedure to examine the institutionalization of those children?

A. Well, we often do have Advocates for children under 13. Bureau of Child Welfare is an Advocate in our city for children under 13.

Q. You mean in other contexts?

A. In other contexts, right, and I think that contexts can be extended. As I said, there may be the perception or the experience, rather of feeling hopeless and helpless in this situation if the child's needs are not being met.

I would also say about school age kids, and adolescents, that there is particular attention that they pay to issues of fairness, that fairness and what is just is a very important issue in the development of children—of school age and of adolescents, and we often see children being able to repeat rules and to have clubs with very elaborate guide lines to follow so that they are very sensitive to issues of fairness, and it has been said that some children would rather be fair than be loved. So, there is a sense that a judicial hearing responds to in children.

(27) Q. Dr. Feiner, with reference to the need or the desirability for having judicial commitment hearing for mental hospitalization, could you tell us whether you think there is any special difference in the psychological make-up of adults, vis-a-vis children which would mean that it

is appropriate for adults to have hearings but for children not to have hearings?

A. Well, I would see some differences, but I could see them even in answering the reasons for children to have hearings—I mean adolescence is a period of life where—in which the person experiences the feeling of being an outsider. One can see this in the kinds of identifications that adolescence makes of minority groups or outlaws, all kinds of outsiders, so the adolescent often has the outsiders view of injustice, of being alone, of being isolated, of needing some kind of contact and so forth, and if it is not readily forthcoming from one's immediate environment, which it often is not, then one needs it from someone else, and the presence of a lawyer or at least a court hearing, as that possibility can be reassuring.

MR. FERLEGER: You may cross-examine.

Cross-Examination

BY MR. ROTH:

Q. Dr. Feiner, now it is my understanding that you became a psychiatrist in 1970; is that correct?

(28) A. No. I finished my adult psychiatric training in 1968.

Q. And you finished your residency in '68?

A. '67 and '68, right. I combined the third year of my residency with the first year of my Child Psychiatry sub-specialty training.

Q. Have you offered any articles in the field of Child Psychiatry?

A. I have given professional papers, but I currently have not offered articles.

If I may say so, I have been working providing a service for 12 hours a day over the past—at least 5 years.

Q. But you haven't offered any articles; is that correct?

A. That's correct.

Q. Doctor, now when you finished in—did you complete this course of Child Psychiatry in 1970, then?

A. That's correct. I took an extra year of Child Psychiatry so I could work half-time for 2 years in a hospital in a ghetto area of New York City.

Q. When you completed in 1970, did you become affiliated at that time with Lincoln Hospital?

A. That's correct.

Q. What was your role at the Lincoln Hospital?

A. At that time I was the only Child Psychiatrist on the (29) staff, and was responsible for service and supervision of children on an outpatient basis.

Q. Now, is Lincoln Hospital a private hospital?

A. No, Lincoln Hospital is a New York City hospital.

Q. You were responsible for children on an outpatient basis; is that correct?

A. That's correct. Children and adolescents.

Q. But the hospital, I assume also maintained institutionalization on an inpatient basis; is that correct?

A. There were institutional facilities available, but not in the hospital itself. The hospital is located in a very poor area and needs to go elsewhere for its inpatient beds.

It is a sad fact of life.

Q. How would a patient come to you at Lincoln Hospital?

A. The patient would—

Q. In terms of—

A. You mean child?

Q. Child, yes.

A. Most of the time the patients were sent by the schools. Over 90 percent of the children were referred from the schools. Occasionally they would be referred from other agencies or from pediatric departments, and very occasionally would they be self-referred.

(30) Q. And these children are from a ghetto area, I take it?

A. That's correct.

Q. Are you still associated with Lincoln Hospital?

A. I am currently associated with the Lincoln Community Mental Health Center, which is a different facility.

Q. And what is your role at the Lincoln Community Mental Health Center?

A. I am the Director of a Satellite Clinic, and responsible as well for all the child psychiatry that goes on there.

Q. And in terms of your role, how does a patient come to you at that Mental Health Clinic, a child?

A. Exactly the same way, only in this case I have developed programs which have more outreach possibility—potential.

Q. Do you ever have a situation occurring where your evaluation of a juvenile requires institutionalization?

A. Very occasionally, we do.

Q. And what is the process, then?

A. The process is first to work in terms of the child of an approach that I described earlier, that we have on our staff a number of people who are from the community. We are located right in the community. It is extremely easy, and important to us that we go to the source of the complaint—if it is the school, we may go there or request

that the (31) school personnel come to our clinic. If it is the family, we will likely make a home visit. We will extend ourselves in every way possible under the constraints of time and personnel that we have there to try to resolve the problem in ways that will avoid hospitalization.

Q. Now, assuming you have explored all those other alternatives, what occurs then, where it has not been successful to utilize another avenue for treatment?

A. Occasionally there will be need for hospitalization. I am not denying it.

Q. And then what happens, who admits the juvenile in New York?

A. There is an admitting hospital, which is another City hospital, and there are—actually there are a couple of ways that this can be accomplished. There are occasional needs for emergency hospitalization.

Q. I am not talking about emergency hospitalization.

MR. FERLEGER: Mr. Roth, can you let him finish his answer before you interrupt?

MR. ROTH: Well, I will rephrase the question, Doctor, so we won't have to go on avenues that we don't know because of time.

BY MR. ROTH:

(32) Q. With regard to non-emergency—

A. With regard to non-emergencies, we usually have a variety of treatment facilities available to us. We then participate with the family and the child in investigating those facilities. We make a visit with them. We talk to the people there, and we go through a procedure in which the family and the child have the opportunity to freely discuss their opinions of this particular place. We have some

residential treatment centers. We have a children's hospital, which is part of the state system, but what we do is we participate with the family and the child in this procedure.

Q. In terms of admitting a juvenile to an institution, who can do it in New York?

A. In terms of admitting, on an emergency basis?

Q. On a non-emergency basis?

A. On a non-emergency basis, a community physician can do it, I believe and the psychiatrist in the receiving hospital.

Q. Isn't it a fact true, then, under New York law only the parent, legal guardian or next of kin or the application of the director of the institute can admit the juvenile?

MR. FERLEGER: I believe that New York statutes on which the court can take judicial notice would answer that question. I don't think that Dr. Feiner is (33) qualified to speak authoritatively on what the New York statutes say. I think the statutes speak for themselves.

THE WITNESS: What I would like to say—

BY MR. ROTH:

Q. Doctor, with regard to that question now, you have already testified as to admitting procedures, and I am questioning your familiarity with New York law on these procedures.

Now, is that not in fact the case on how a juvenile can be admitted?

A. I believe that it is.

Q. What is the distinction?

MR. FERLEGER: Excuse me, have you finished your answer, Dr. Feiner?

THE WITNESS: Well, I want to suggest operationally that we proceed very much as the child and parent advocates. We consider ourselves to have an ongoing relationship with them, in pursuit of a proper treatment for the situation, and we will have exhausted other community based possibilities before we pursue any kind of hospitalization.

BY MR. ROTH:

Q. Now, in terms of juveniles and their admission process in New York, is it similar to the laws of Pennsylvania?

(34) A. For 16 to 18, the patient has been given notice in writing to the director that they desire to leave.

Q. What about the admission of?

A. An admission, under 16, they can be received as voluntary, on the application of the parents, guardian or next of kin?

Q. And after 16?

A. After 16 the director of the hospital may use his discretion in deciding whether to admit or not.

Q. With regard to release?

A. With regard to release, my understanding is that the patient gives notice in writing to the director of their desire to leave. They must be relieved unless they are—it is an involuntary commitment, at that point they can apply—the hospital can apply for a court order within 72 hours, the date for the hearing must be given no later than 3 days from the time the court order is received and the patient, if the decision is made to commit them, the patient is committed for a period not exceeding 60 days.

Q. Doctor, now with regard to that, is it your understanding of the New York law that if a patient is under 16 years of age that patient may notify the director of his release?

A. That is my understanding.

(35) Q. And the patient—is it finally your understanding that the patient can be detained at the institution for 72 hours during which time a county court or the Supreme Court should be notified? Is that correct?

MR. FERLEGER: I have to object, again to this whole line of questioning in Mr. Roth's attempt to get the New York statutes into the record through the words of somebody who is not a lawyer, who is not familiar with the case law in New York; not familiar with amendments which may have been enacted now or a year ago or 2 years ago under the New York statute. I see Mr. Roth has a copy of the New York statute, and I am sure if he wants to introduce that as an exhibit to save Dr. Feiner's time and to acknowledge the fact that he is not an expert in the law, I wouldn't object to the New York statute being introduced as an exhibit. I don't see any necessity for Dr. Feiner to contend to be an expert in the law. He is a Child Psychiatrist, not a lawyer.

BY MR. ROTH:

Q. Dr. Feiner, with regard to the questioning that I have been imposing, in terms of the release provisions, now, you have already testified that you are somewhat familiar with the admission and release procedures, I would assume, in New York with regard to the release provision. Is it your understanding (36) that a patient can be detained 72 hours?

A. That is my understanding.

Q. And thereafter, according to court order, could be detained as long as how many days?

A. No longer than 3 days from the time the court receives the notice.

Q. And then when does the hearing occur, do you know?

MR. FERLEGER: The record will show that Dr. Feiner raised his hands in a shrug of speculation.

MR. ROTH: I think Dr. Feiner is capable of answering, either yes or no or explain it.

THE WITNESS: I am not sure of the answer to that question.

BY MR. ROTH:

Q. Have you ever been involved in any of these proceedings?

A. With the court? No, I haven't.

Q. With regard to—I notice in answering some of our questions on the admission and release procedures you were reading from something. Could you explain what you were reading from?

A. I happen to take down some notes from Section 3113 of the New York State statute.

Q. Dr. Feiner, are you aware of any judicial proceeding in (37) New York prior to the admission of a juvenile by his parent under 16 years of age?

MR. FERLEGER: That is totally irrelevant to this case whether or not Dr. Feiner agrees with or disagrees with New York law. He, of course like all of us obeys the law in New York and doesn't make his own laws, and whether or not there is a judicial

proceeding in New York doesn't matter in terms of his testimony, just as his testimony isn't affected by the fact that in Tennessee similar laws are ruled unconstitutional.

BY MR. ROTH:

Q. Not withstanding the testimony by opposing counsel, his objection is noted, would you answer that question?

A. I would simply say that I follow the law as I understand it when the situation arises. I—if you are asking me my opinion of the law—

Q. I am not. I am asking you if there are any judicial proceedings afforded a juvenile prior to admission by a parent in New York.

MR. FERLEGER: The law speaks for itself.

THE WITNESS: I would agree.

MR. ROTH: I would appreciate, Mr. Ferleger, if you would allow your client and your witness to answer or if (38) you would object accordingly.

THE WITNESS: I have availed myself of immediate access to legal advice as a condition of my work. I have a number of lawyers who are quite familiar with this law, immediately available to me for advice when these matters arise.

BY MR. ROTH:

Q. Doctor, now you testified, and I will come back to the admission procedure, but with regard to some other things, you testified that the children's behavior, in many instances is a result of the environment in which he is located. Now, is it your testimony that many juveniles are

the scapegoats of familial problems, and as a result find themselves in institutions?

A. Yes, I will.

Q. And how do you arrive at that opinion?

A. I arrived at that opinion by making an evaluation of a family situation, which I think has as much or if not more legitimacy as any valuation of any individual child. We simply do it by an evaluation of a family, of a family setting with the child often in his family, and we do the interview on occasion with the entire family.

Q. Well, how many juveniles have you seen institutionalized (39) in New York incorrectly as a result of family problems?

A. Many. I would indicate at the same time that the diagnostic interview is not only a diagnostic interview, the interview is an attempt to defuse a potentially explosive situation. This family has come in crisis. We do not set ourselves apart, and do a detached kind of interview. We are very active, and very much desirous of defusing this situation and orienting ourselves to this family's problem.

Q. Okay. You practiced, I recall in a ghetto area; is that correct?

A. That is where I—that is where my clinic is, that's correct.

Q. Do you find that most of the people in that area avail themselves of either the law or medicine when they need it?

A. I don't know what that means.

Q. I mean do they make use of contacting their neighborhood legal service attorney or their community oriented physician or are they afraid to, in many instances?

MR. FERLEGER: That question is so vague. Of course sometimes people do. Sometimes people don't.

MR. ROTH: Mr. Ferleger, if you want to object, I don't like the idea of your testifying on behalf of the (40) doctor.

THE WITNESS: Obviously sometimes people do, because all of us that work there in any service capacity are overwhelmed, and whether we reach as many people as need our services, I can't tell you and I seriously doubt it.

BY MR. ROTH:

Q. Do you find that because—obviously I would think you would have some understanding of the environment in which you work that either people are hesitant or reluctant to contact attorneys or doctors.

A. Or people are simply demoralized and overwhelmed with such a variety of problems, that it is hard to set priorities, and their experience with service agencies is so demoralizing that they seek other solutions, often desperate ones.

Q. Do you feel that by having a juvenile participate in a judicial proceeding prior to any admission, that this may cause a reluctance on the part of any parent to utilize this system in that area?

A. I think it would certainly dignify the whole system to the juvenile.

Q. I didn't ask you that, I asked you whether or not it would?

A. I would tend to think not, because my experience often is, (41) as I have mentioned, that parents very often are there at the behest of another agency, such as the

school, and they are doing it because somebody who they have been led to believe has their interest in heart has sent them to a facility, and they are going ahead with it, because they feel that the consequences of not going ahead with it are worse, and they have been led to believe that hospitalization can be a benign situation, so I would say that very often availability of legal help in these situations is a tremendous relief to everybody involved.

Q. Now, in Pennsylvania are you aware of how a juvenile may end up at an institution?

MR. FERLEGER: The question is not clear as to whether you mean whether the statutes are in the doctor's awareness.

MR. ROTH: I am asking the doctor—of course he is aware of the sections being questioned, and I am also asking practically if you had any awareness.

THE WITNESS: No practically I haven't. I haven't worked in Pennsylvania.

BY MR. ROTH:

Q. Okay. With regard to the procedural safeguards, if you will that I attached to a juvenile—

(42) MR. FERLEGER: Are you referring to the regulations?

MR. ROTH: Yes.

I believe there was a statement made earlier by your attorney—

MR. FERLEGER: I am not Dr. Feiner's attorney.

MR. ROTH: By counsel for Plaintiffs, who is using you as a witness, that there was a brief evaluation done prior to admission of juveniles in institutions.

Now, according to your reading of the regulations, do you find that necessarily—do you find any words in there that say "Brief evaluation"?

THE WITNESS: No.

BY MR. ROTH:

Q. Now, with regard to the process in Pennsylvania, there are base service units. Do you know what base service units are?

A. I do not.

Q. With regard to the procedure in Pennsylvania whereby a juvenile is—well, let me ask you this, strike that.

What is your understanding, based upon your reading of the regulations of how a juvenile would arrive at an institution?

MR. FERLEGER: I think the regulations speak (43) for themselves. If Dr. Feiner wants, he can read them, because the only thing he has to base his understanding on is a text of the regulations, so any interpretation of that would be irrelevant and superfluous.

MR. ROTH: Well, the question remains doctor, and it is essential, as you know, Mr. Ferleger that Dr. Feiner knows what is in question, and his opinion of the same, and I am asking you, based on your reading of the regulations and so forth, can you tell me what your understanding of Pennsylvania procedures are for the commitment of a juvenile?

THE WITNESS: I do not understand—it does not indicate the patient flow, if you will. I have simply been made aware that there [are] a number of juveniles who end up in a hospital still against their will regardless of what is presented.

BY MR. ROTH:

Q. And how did you arrive at that factor that juveniles are hospitalized against their will in Pennsylvania?

A. I have been apprised through the material furnished regarding this case.

Q. What specific instances are you referring to?

A. Well, I would say in general that if I am asked about—I mean if you want to ask me some specifics about some specific (44) cases, I would be happy to comment on them. I think I actually am, in testifying in regard to the involuntary hospitalization of juveniles.

MR. FERLEGER: I might note for the record that Mr. Roth has stipulated to tables and statistics which were written with his assistance and help indicating that juveniles do in fact on occasion object to commitment, and that, it seems to me, is not a disputed aspect of this case. We know that some children don't want to be in hospitals and some children do.

BY MR. ROTH:

Q. There is no dispute as to the objection. The question remains as to how you know that juveniles are incorrectly admitted to institutions in Pennsylvania?

A. I did not say incorrectly.

Q. Inappropriately?

A. I said "Against their will."

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Q. Now Doctor, with regard to some of the comments you made of Dr. Max Sugar's deposition, did you ever hear of Dr. Max Sugar?

A. I believe I read something that he has written. I have seen his name.

Q. Do you know, in review of that deposition, which you (45) said you have done—

A. I said that I did not do an entire review of it.

Q. What parts of it did you review?

A. I read about half. I read his depostion and you were questioning of him.

Q. Pardon me?

A. I read his statement with your questioning. I did not get beyond that.

MR. FERLEGER: You are referring to the direct examination of Dr. Sugar by Mr. Roth?

THE WITNESS: That's correct.

MR. FERLEGER: You read that?

THE WITNESS: That's right.

BY MR. ROTH:

Q. Do you recall Dr. Sugar testifying as to the problems that would occur if a judicial hearing were afforded prior to admission?

A. Yes. I recall that.

Q. With regard especially to the delay in treatment?

A. Yes.

Q. Do you feel that is an incorrect response?

A. Because—yes, I do, because as far as I am concerned, treatment begins the very first time that the patient, and/or (46) family steps foot in any mental health facility; that, to me is when treatment starts, not at some point at which somebody enters the ultimate door.

Q. But again, Doctor, taking into account, if you will the procedures in Pennsylvania whereby children are just not placed on doorsteps of institutions, but have been subpoenaed and evaluated by several psychiatrists prior to the ultimate detention of them—

A. Yes.

Q. Don't you feel that there has been adequate safeguards provided at that point?

A. No, because I question the evaluation, and as to whether it takes into account the entire context of the child's life.

According to Dr. Sugar, he would evaluate the child and he does not seem in the testimony to be entirely responsive to the kinds of communications that go on in the family, and he seems to assume in his testimony that parents exist all the time for the good will and the best interests of their children. I question that seriously.

Q. Now Doctor, you did not read the cross-examination, I take it of Dr. Sugar's cross-examination?

A. No.

Q. In which questions were asked by Mr. Ferleger, regarding (47) the whole familial situation?

A. Yes.

Q. So then I guess it would be difficult to ask you questions with regard to Dr. Sugar's responses?

A. I think so.

Q. Since he did take into account the entire family situation at that point?

A. My only response to that would be that it can't be a primary importance to him if he did not mention that on initial or direct examination.

Q. Well, there are some things in regard to it on direct, but let me ask you, as a professional, do most psy-

chiatrists just evaluate a child, a juvenile without evaluating the familial situation?

A. There are different ways of evaluating the familial situation, very often it will be done discreetly—that is one person will evaluate the child, one person will evaluate the parent, another person will interview the other parent. This is a traditional way that is often done in child guidance clinics.

What I am suggesting is myself and many other people see everyone together in the family, whereby different kinds of information are forthcoming.

(48) Q. Are you saying, then, that it is not customary for a psychiatrist to evaluate the entire situation from whence a patient comes, a prospective patient?

MR. FERLEGER: That has already been answered.

MR. ROTH: I am asking you that question.

THE WITNESS: That it is customary to evaluate the entire situation to develop supportive evidence for the disturbance of this child? It often is done to get history of this child, which the child himself cannot furnish, but very often it is done in order to get an understanding of a parent's own life and a parent current situation.

I can give you some examples.

BY MR. ROTH:

Q. Well, that is all right.

MR. FERLEGER: He is concluding his answer to your question.

THE WITNESS: Let me give you one example.

A child that I saw ran away—brought in to see me when he was found some miles away from where he lived. This was an 8 year old child and taking the history of the family situation, it was discovered that this child was in fact not the child of this father, but the child of another father who ran away from the family. This was a secret which the family (49) had a tacit understanding of keeping. Nobody was allowed to talk about it, but everybody knew it, including the child, because he was 3 years old and other relatives had supported his sense of what was going on. The fact that the family couldn't talk about it meant the child had to act it out, which he did and this was his way of dealing with an issue that was not allowed to be talked about in the family, but had to be acted out in terms of this child being like his original father, trying to find his original father and so on. As soon as this issue was opened up and discussed openly, the running away ceased.

There is an example of a child whose behavior was induced by the collusion of his current parents.

BY MR. ROTH:

Q. Are you saying that is a normal, that generally parents and psychiatrists act in collusion or conspiracy to institutionalize an individual?

A. No, not at all. I am saying that very often for their own needs and their own anxieties and the complicated aspects of their own nature, parents may in fact be unable to talk about certain aspects of their lives openly, and I would say that it is not always recognized that these situations occur, and even if it is recognized, I am saying it is not always dealt (50) with—you see that is the other

part of this, you see even if the psychiatrist does do an evaluation of the situation, it still does not lead to the implementation of a treatment plan that includes the entire family or that includes a psychiatrist orientation, in part because many facilities are just not tooled up to do crisis work, and they only have one alternative, which is to hospitalize.

I am suggesting that it is important that clinics and emergency rooms and other facilities be tooled up to intervene immediately so that whatever facts they do discover can be included in an appropriate treatment plan.

Q. Well, you said that when any great alteration occurs and you felt that psychiatry should not be able to make the determination, that they should submit their evaluation. Would that also occur for any other treatment plan other than institutionalization, in your mind?

MR. FERLEGER: I object to that question. I believe he has already testified that institutionalization is a much different, more serious process than other kinds of treatment.

THE WITNESS: I will consider Mr. Ferleger's objection to be consistent with my belief.

BY MR. ROTH:

(51) Q. Now, you stated that Dr. Sugar talks about the traditional point of view and that your point of view is more innovative; is that correct—or better?

A. I'd say that.

Q. Based on your experience, I mean?

A. I'd say that my point of view offers more alternatives.

Q. Is your point of view better, based on your three years of experience?

A. Does it help me for people? Does it work for me? Does it work for others that have used it? Does the literature say that it works? I'd have to answer yes.

Q. Well, where do you arrive at this new innovation?

MR. FERLEGER: Excuse me, that is a total misstatement of his testimony.

THE WITNESS: Absolutely. I have no—I'm sorry—

MR. FERLEGER: He stated on the report that this is a development in the total field of child psychiatry over the past ten years. Dr. Feiner didn't think it up, it was taught to him and every other person who studied child psychiatry in the past ten years. It is Dr. Sugar who is behind the times. We are not talking about innovations, we are talking about regular practice established—accepted (52) practice.

BY MR. ROTH:

Q. Well Doctor, let me ask you this:

If this is established practice, why is the first state or one of the few states whose statutes and laws are becoming attacked as unconstitutional, why aren't other states utilizing judicial procedures prior to admission of juveniles by parents, if this is so recent or if it has been going on for ten years?

A. What I am suggesting is that what is going on for ten years is a treatment motility that I am suggesting be applied for more situations than it currently is. It is likely that it is being applied in many places in Pennsylvania. I simply am reflecting to you the current state of the art as I know it, from what I read and the meetings that I attend and the colleagues I consult.

Q. Let me ask you this, in terms of what goes on in Pennsylvania and for example if I had a child and were having that child admitted to an institution, as the ultimate, if you will and so I went through—let's take it, if I were from a poor socio-economic background, could not afford a private psychiatrist at the outset to evaluate my child, et cetera, et cetera, including home life or anything which you might think was relevant which goes on in Pennsylvania and I went to this (53) base service unit where I evaluated my child, made recommendations they went through their entire process, okay, and then there was a recommendation that the best alternative, after making other recommendations of other outpatients through the county mental health mental retardation unit, of which there are numerous ones throughout the state, if they found in the best interest of the child that institutionalization would be a paramount and then I went to the institution and the director, then, according to the laws as you have read them in Pennsylvania has another independent psychiatric examination made to make certain that the child does not need institutionalization and that occurs and the child is detained in the institution receiving treatment, knowing full well that according to the safeguards that he objects at any time within 48 hours thereafter he is going to be afforded counsel and go through a hearing, do you find that to be inappropriate?

A. You say so much that, first of all I question the child is already receiving treatment. I think a child strongly believes that he is not—that he does not feel that it is necessary for him to be in an institution is not likely to acquiesce to the kinds of appropriate treatment within the first 48 hours, so I can certainly question that aspect of your assumption.

(54) Q. Well, Doctor let me clarify something, so you don't misunderstand this.

It is not necessarily within the first 48 hours, it is within 48 hours whenever he makes the objection, if he makes the objection at admission or subsequent thereto—we are talking about within 48 hours after that objection counsel will be afforded him?

A. Yes. I simply am saying I do not see why it can't be done before hand. After all, you have talked about an elaborate procedure that goes from one place to another to interpose this procedure before the child is admitted seems that it will afford more alternatives in case the child's position is upheld. It will decrease the amount of alienation, and those 48 hours are more in which the child has to stew and will afford the opportunity for a reconciliation if that is going to be the fact—I mean after all, if we say that there is going to be a judicial hearing and we recognize the fact that the child in fact may be upheld in his request, it is not inevitable that they are going to agree—I would assume that all of the recommendations are to be adhered to.

Q. But doctor, that assumes that when a juvenile is evaluated through the base service unit and implementation of (55) any programs as to occur, it doesn't occur until after institutionalization and that isn't necessarily so?

A. I don't understand that.

Q. In other words when a person is being evaluated, either in New York—I'm sure through your county health mental retardation units or in Pennsylvania, I would assume that psychiatrists, when they see that the problem exists are going to establish procedures to help the juvenile—they are not just going to sit by and not help them?

A. Yes, I think that is probably true, but I think we can't presuppose that amount of good will all of the time when we are dealing with somebody's rights, and I would assume that during this time the psychiatrist would be attempting to establish a rapport with this client, to perhaps do some persuasion to feed back observations, to make recommendations, and so on and even if that isn't—and if that isn't taken up by the child, I think the child should still have resource to other avenues before he is hospitalized.

Q. Well, what about the fact that when the child is hospitalized, that treatment begins when he becomes hospitalized?

A. What treatment are you talking about?

MR. FERLEGER: Objection.

MR. ROTH: I am talking about the fact that (56) recommendation and treatment plans that have been initiated prior to his institutionalization have occurred and the treatment program continues.

MR. FERLEGER: Objection, that question must be objected to on the basis of Mr. Roth is testifying about some treatment plans that are established for some unknown patients. That is not part of the record in this case.

If Mr. Roth wants to ask the doctor about his experience as director of his mental health center, then he can testify about whether or treatment takes place there, but you certainly can't testify and Mr. Roth can't testify about some alleged treatment in Pennsylvania.

BY MR. ROTH:

Q. Now Doctor, you have testified that rather than having someone stew for 48 hours—and I am merely advising you that that is not necessarily the case, and I am saying if in fact a person does receive treatment, continuous treatment, aren't those needs of the person met?

A. Mr. Roth, I'd like to correct a misconception I think you are implying, that is a person does not receive treatment, a treatment is a collaborative effort, and a person does not have treatment poured into him. Psychiatric treatment is a long arduous affair which involves the development of a (57) relationship of trust, and it cannot be done in a coercive way, so when you say "treatment," I question what in fact you mean.

Q. Well, when I say "treatment," of course not being a psychiatrist I am saying that some plan has been established by a psychiatrist that of evaluating the juvenile prior to as well as at admission, and that that plan, whatever it be is continuing, and I am saying assuming that were to occur, how—why do you feel, then that a hearing subsequent thereto, if necessary could not be held?

A. Because I question the possibility of treatment occurring under those circumstances, and I question the possibility that we are not, by enforcing this coercive situation, ruling out this patient for any subsequent treatment, at any opportunity in the future to voluntarily seek help from a mental health facility. My feeling is that this experience is more likely than not to be a negative one.

Q. Doctor, are you ever aware of situations where, because of reliance upon a judicial system, whether it be for an emergency hearing—no, I am sorry, whether it be for an emergency or non-emergency that the judicial process has been slowed to the extent that the person has com-

mitted suicide because they weren't able to get into the institution right (58) away?

A. Well, I—

MR. FERLEGER: I don't see how that is relevant. That procedure is for children. When we have judicial proceedings in Pennsylvania for adults, and if Mr. Roth is suggesting that adults be treated as children in Pennsylvania, that question is irrelevant.

MR. ROTH: Notwithstanding Mr. Ferleger's gratuitous remarks—

THE WITNESS: I would like to add, if you are hypothesizing an emergency situation, that isn't the statute under question.

MR. ROTH: I am not asking you about this statute under question, I am asking you in your professional opinion, or in your knowledge, have you ever heard of situations where a person perhaps died with their rights on?

MR. FERLEGER: Could you lower your voice, Mr. Roth? You are yelling.

MR. ROTH: Mr. Ferleger, I am sorry, I am not yelling and I am sorry you are so sensitive that you can't listen.

THE WITNESS: I am amazed that that—at your hypotheses, but I won't question that, but I have not (59) heard of such a case, quite frankly.

MR. FERLEGER: Mr. Roth—

MR. ROTH: Mr. Ferleger, I would like to continue with the examination.

MR. FERLEGER: Your questions are becoming a bit redundant and far afield from the case. Dr. Feiner has to leave in about two minutes in order to make a train, and if you have any relevant questions to ask, I wish you'd ask them now so that the deposition can be concluded.

MR. ROTH: Mr. Ferleger, with all due respect, I have many more questions to ask of Dr. Feiner.

With regard to that, the Notice of Deposition says "Is expected to be completed within two hours." Subsequent to that time, we had correspondence with our own staff indicating that we may need additional time, and there was no objection to that.

MR. FERLEGER: If we need additional time for relevant questions, I have no problem with that.

MR. ROTH: Well, I think the Court can very well determine what questions are relevant and irrelevant.

MR. FERLEGER: You are asking irrelevant questions. They don't seem to me to be appropriated if we can't conclude by the time that Dr. Feiner has to make his (60) train, then we will be glad to continue it to another day.

MR. ROTH: Well, I have numerous questions for you, Dr. Feiner.

BY MR. ROTH:

Q. Dr. Feiner, do you feel that there are differences between juveniles and adults in terms of their self-awareness regarding use of institutions, of they needed to?

A. No.

Q. In other words you read Dr. Sugar's deposition and he felt that youngsters have a lot of hormonal changes, secondary changes, growth changes—he felt that these do not become complete at the late adolescent years, and he felt that there was very much a distinction between adults and juveniles in terms of development?

A. Well, you didn't ask me that question. Of course there are. You asked me regarding the use of institutions, and I suggested—

Q. In regards to their awareness, I am sorry?

A. In regards to their awareness, I think they are individualized, and I wouldn't be prepared to make a generalization. I have seen numerous adults who were not prepared to take advantage of the institutions available to them in this society.

(61) Q. Well, one of the thrusts of this lawsuit is to have sections under the act declared unconstitutional which treat juveniles differently from adults. Is that your understanding?

A. Yes.

Q. And there is a possibility that if that were so done, that juveniles would be afforded the same rights as adults to admit and release themselves?

A. That's correct.

Q. Now, do you feel a child aged 5 would have any capacity at all to even make that determination whereas an adult aged 19—where are the differences?

A. Obviously there are significant differences, but if—I can foresee a child with an Advocate participating in a situation in which the child is realized into another situation or home.

Q. Do you think it is feasible that that occur, if—you know—for juveniles to admit and release themselves as adults do in Pennsylvania?

A. Do I think it is feasible?

Q. In your professional opinion?

A. I would not be here if I did not think it was feasible.

Q. How would a 3 year old even approach that?

MR. FERLEGER: Mr. Roth, your questions—(62) and I am waiting for you to ask about the 3½ and 4½ and the 4 and ¾ year old—your questions are just prolonging this deposition in a ridiculous manner. Obviously—and your own Dr. Sugar testified that 13, 14, 15, 16 and 17 year old kids could go in and out of institutions. We are not talking about—

MR. ROTH: Do you have an objection?

MR. FERLEGER: For younger children—

MR. ROTH: Are you testifying or do you want to object?

MR. FERLEGER: This is my objection, Mr. Roth, for younger children as the doctor testified, an Advocate is the one who would be speaking to the court, not the 3 year old and for a 17 year old severely retarded person it would be an Advocate or a guardian ad litem. Your questions are just absurd.

BY MR. ROTH:

Q. The question still remains, Doctor, in terms of the procedures which plaintiffs seek.

A. I cannot foresee that possibility of the child speaking for himself, but should the possibility ever come up, I would think that those rights would extend—I mean

—it is certainly unlikely, if not impossible that that would occur (63) with a 3 or 5 year old, but where are you going to draw the line? There are certainly some sophisticated 9 and 10 year olds, just as there are some very naive 30 and 40 year olds.

Q. Well, do juveniles who need hospitalization necessarily recognize it?

A. I think that juveniles need hospitalization on occasion, and often do recognize it. I think that adults who need hospitalization often do not recognize it, also.

Q. I am asking about juveniles. Do you have juveniles that tend to avoid reflection and introspection?

A. Juveniles may make their needs known through behavior.

Q. Let me ask you this.

Is it your testimony in part that you feel parents really do not operate in context of this situation for the well-being of their children?

A. No.

Q. Do you feel by and large parents do?

A. I think it is a very mixed bag. I am suggesting where there are enough indications where they don't require some protection, and I hope to work in a situation where we see numerous cases of child abuse and neglect—I am quite sensitized to that possibility. We are not talking about one case.

(64) Q. Have you ever admitted a child to an institution?

A. Yes, I have.

Q. To which institution?

A. I have admitted a child to Bronx Municipal Hospital Center.

Q. Were you the admitting physician?

A. Yes.

Q. And how did that occur?

A. That occurred by my following the procedures that were available to me at that time and operating under the guide lines which the institution functioned. I have since been able to participate in changing that situation to make it more flexible, and to decrease the possibility of a child being admitted under those circumstances.

Q. Do you admit many children to institutions?

A. No. I have not admitted a child to an institution personally in some time.

Q. Are you opposed to institutions?

A. Absolutely not. Absolutely not. I am not talking against admitting children to institutions, I think they serve useful functions, serve a useful function when used appropriately. I will mention another alternative which is being used as well, and that is day treatment centers where children spend their days in a community setting living at home.

(65) Just to add another alternative to the family of psychiatrists.

Q. When a juvenile comes to your facility, how long a process occurs in terms of making a recommendation of whether or not the juvenile needs an alternative type of care?

A. What procedure usually occurs?

MR. FERLEGER: That has already been testified to, Mr. Roth.

THE WITNESS: It has been testified to.

We will gather as much information as we can, and as many contexts as we can involving as many people who can provide information and opinions.

BY MR. ROTH:

Q. In the clinic where you work, how many psychiatrists are there and how many patients come in daily?

MR. FERLEGER: Objection, Mr. Roth. Dr. Feiner has to leave in—as a matter of fact right now for a train. If you have relevant questions, I wish you'd ask them quickly so we can conclude the deposition today rather than continuing it. If you want to submit Interrogatories, if you have any relevant questions left, that is fine, but the number of patients at his institution is irrelevant.

BY MR. ROTH:

(66) Q. How many patients come into your facility daily?

A. Maybe 50. I—you know, I really have to leave. I have an important and professional commitment in New York.

Q. Dr. Feiner, I have still several questions.

Do you often testify?

A. No, not often at all.

Q. How many times have you testified in the past year?

A. None.

Q. In the past 3 years?

A. Once or twice.

Q. Are you being compensated for your testimony?

A. No, I am not.

Q. In your opinion, if a methodology of treatment occurred once the juvenile was seen by whomever in terms of psychiatric evaluation, if a treatment plan were established at that point, and if there were any alteration of that treatment plan in terms of either having the patient be seen at a facility many times a week or having the patient institutionalized or anything of that sort, do you think at that point a judicial hearing should occur?

A. I think a judicial hearing should be available to a person at any time they chose to request it, and I think that it is the mental health person's legitimate responsibility (67) to explore that request, but when—I don't think he can do more than explore it, and under its meaning and the reason for it occurring at that particular point.

Q. What would happen if—if you started a treatment program for a juvenile and the juvenile objected to that treatment program, do you think a hearing should be afforded at that time and that the treatment program should stop?

A. No. I think the juvenile would—I would try to persuade, I'd try to prescribe, and if the juvenile then chose not to participate in treatment, despite all of the technical maneuvers available to me, I would not be able to treat that person, nor would I want to coerce them into treatment, because I would think that I would lose them for the possibility of treatment forever.

There are often occasions where juveniles will want a taste treatment, a little bit to see what it is like when they are brought there—they want to see who is this doctor, what is it all about, and then they will leave, because they want to come in on their own, and I have seen this happen a number of times where a juvenile has terminated treatment orally; they have said "Fine." They have gone out, they have done what they have had to do and they have come back on their own and treatment has really begun at that point.

(68) Q. But the question still remains, you feel if a juvenile objects to any point and wants a judicial hearing, that a judicial hearing should occur; is that correct?

A. Are you talking about a juvenile in a hospital?

Q. No, I am talking about when you establish a plan, if the juvenile doesn't want to participate in the plan—

A. Oh, if I am an outpatient therapist for this juvenile, I regard that completely as a voluntary contract. We use the term "contract" not in your terms, but we have established very early an understanding between us that this is completely voluntary; that it is completely confidential and at any time either one of us feels that things aren't working out and I reserve that right myself, to say that this is a situation that I don't think I can deal with, I reserve—we each reserve the right to terminate that relationship.

Q. But with regard to the question itself, if, in the best interests, in your professional opinion as a psychiatrist you feel that the juvenile should be treated, either on an outpatient basis or any other basis and the juvenile objects at that time, you feel that a hearing should be afforded the juvenile?

MR. FERLEGER: He testified—

MR. ROTH: He didn't answer the question.

(69) MR. FERLEGER: —that that implies the institutionalization, not outpatient treatment.

THE WITNESS: I have never heard of a situation—

MR. ROTH: I am not asking you what you have heard, I am asking you your professional opinion, Doctor.

MR. FERLEGER: Well, an opinion about something that doesn't happen is sort of useless.

THE WITNESS: I would have serious feelings that if a court determined the juvenile had to stay in treatment that anything useful could be accomplished under those circumstances.

BY MR. ROTH:

Q. Well, don't you feel that juveniles could be negative to admissions anywhere to institutions or day care programs but nonetheless be still co-operative in the treatment program itself?

A. Well, maybe. Maybe. Maybe a certain percentage are, but not certainly not a hundred percent.

Q. Do you find that juveniles—just by the mere chronological age are recalcitrant and as a result object to any type of methodology?

A. Oh, no, I find that recalcitrant is part of the program (70) and part of the give and take that people deal with kids have to learn to understand.

Q. Yes, but as that being part of the charm, isn't that part of the effect of objecting to anything?

A. It is not for me to coerce. I am a service employer. I am a therapist.

Q. Based on your experience, don't you find that juveniles generally object to confinement of any sort?

MR. FERLEGER: Most adults, I know object to confinement of any sort.

MR. ROTH: I am sorry, I am asking the question to Dr. Feiner.

THE WITNESS: That is the kind of idea I was trying to phrase. I think that we have due process situations, because most human beings object to confinement. If you will excuse me, I really have to go.

MR. ROTH: Well, I still have many questions.

MR. FERLEGER: How many questions?

MR. ROTH: Several.

MR. FERLEGER: Three?

MR. ROTH: Several.

MR. FERLEGER: Is several three or twenty?

MR. ROTH: It would also depend upon (71) Dr. Feiner's responses.

MR. FERLEGER: Well, at this point do you have three or twenty?

MR. ROTH: I have several.

MR. FERLEGER: Well then, we will have to conclude the deposition.

Would you like to continue the deposition to another date?

MR. ROTH: I would like to finish.

MR. FERLEGER: Or one more minute or so, if you have several we can get them done.

MR. ROTH: Mr. Ferleger, it is a shame that when you sent out the notice you said it was going to be at least two hours, and then in contact with your own staff members, if asked if we could go beyond that because we knew we would need time, we were assured of that.

MR. FERLEGER: At that point, we didn't know that Dr. Feiner had another commitment at 5:00, and we have, of course the same problem that

we had when you wanted the deposition of Dr. Sugar restricted, because he had to go give a speech and I cooperated at that point, and we finished the deposition in time for him to make the speech.

MR. ROTH: Oh, Mr. Ferleger, you showed up (72) 45 minutes late. How can you say you cooperated?

Dr. Feiner, let me ask you this, now, you have testified on direct examination that you think confinement to a general hospital is different, for example you brought up the illustration about someone who is affected with tuberculosis would be different than a mental illness, if you will. Why don't you think a hearing, prior to admission of a general hospital should occur?

THE WITNESS: As far as I know, I mean I can't be specific about the law, but I think that there are probably Jehovah's Witnesses who do avail themselves of those opportunities.

BY MR. ROTH:

Q. Well, I am asking you, though, in confinement of any person to an institution, be it a general hospital or a state institution, don't you think—you know—for a juvenile that a due process hearing should occur?

A. I am looking—

Q. Go ahead.

A. I think that there is some substantial differences between a physical illness and emotional difficulties.

Q. Don't you think parents, as you testified could misutilize a situation and put their juvenile, their child into a general (73) hospital?

A. Oh, sure, sure, and may be there should be due process.

MR. FERLEGER: Do you have further questions, Mr. Roth?

MR. ROTH: Yes.

MR. FERLEGER: Okay, the deposition will be continued to a date that I will notify you of, Mr. Roth.

Thank you, Dr. Feiner.

MR. ROTH: You can show on the record that I object to the continuation of the deposition on the basis that I was assured that I would be able to fully cross-examine the witness. I have not completed my cross-examination of the witness; that I was told the deposition would occur for at least two hours and more, and in subsequent conversation with Mr. Ferleger's staff and confirmation in writing of the same—

MR. FERLEGER: We have no problem with the deposition being finished, so that Mr. Roth will be able to finish his questions, and that is the very reason why we have continued the deposition, so that all parties can have the benefit of Dr. Feiner's testimony.

MR. ROTH: Well, I question the whole deposition in terms of Mr. Ferleger's misleading an unfair and inappropriate statements regarding the length of the deposition.

(74) (Whereupon at 3:18 the deposition was adjourned.)

File L

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action Number 72-2272

Kevin Bartley, et al.,
Plaintiffs

v.

Haverford State Hospital, et al.,
Defendants

ORDER

AND NOW, this 21st day of August, 1974, after consideration of the parties' proposed Final Pre-Hearing Order and after a conference in chambers on July 30, 1974 regarding said order, it is hereby ORDERED:

1. Final hearing and argument herein shall take place on September 9, 1974 beginning at 10:00 A.M. in a courtroom to be designated, and on September 11 from 9:30 A.M. to 1 P.M.

2. Pre-trial briefs are not required. Any briefs which the parties may wish to submit must be filed on or before September 3, 1974.

3. The parties' Final Pre-Hearing Order, filed including their stipulation of facts and other matters, is

fully approved and adopted by the Court together with the following amendments and additions. References are to the pages and paragraphs of said order.

a. Defendants shall be permitted to call as witnesses Dr. Derek Miller of the University of Michigan and Dr. James Masterson of the Cornell Hospital in New York.

b. The "Discharge and Readmission Data" (Page 10, Par. 3) shall not be admitted.

c. The question of monetary liability of Defendants shall be briefed if and when it becomes an issue herein (Page 10, Par. 4).

d. Paragraphs 1 through 8 at pages 14 through 18 are admitted and included in the factual stipulation. Defendants shall be permitted to comment on and to make a statement on these facts. Defendants may prepare an exhibit by September 2, to be approved for accuracy and completeness by Plaintiffs, regarding the admission of the following patients' cases listed on pages 14 and 15 (noted here by institutional number):

Pennhurst #402
Polk #13,173
Polk #13,077
Western #281
Western #288
Polk #13,212
Western #144
Western #15
Western #67
Western #131

In their review of patient records for the purpose of preparing this exhibit, the parties shall protect the confidentiality of the patients' records.

e. The Plaintiffs' witnesses are as indicated at page 19 of the aforesaid order. The Defendants' witnesses are:

Dr. Derek Miller
University of Michigan
Ann Arbor 48104

Levon Tashians, M.D.
Institute of Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa. 19139

Barbarba Armstrong, M.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

Dr. James Masterson
60 Sutton Place South
New York, N.Y.

James Gibbs, M.D.
Director of Child and Adolescent Psychiatry
Sheppard-Pratt Hospital
Baltimore, Md. 21215

Both parties agree not to contact the witnesses without approval and presence of opposing counsel.

f. Plaintiffs' Exhibits 2 and 3 may be offered at the hearing (page 21) and the Court will determine their admissibility and weight.

g. Plaintiffs may take the deposition of Dr. Joel Finer in Philadelphia, Pa. which deposition may be admitted as a trial deposition.

h. Plaintiffs shall submit three copies of Dr. Barbara Armstrong's deposition to the Court with those portions to be admitted underlined in red. All portions on which the parties disagree shall be admitted.

i. The deposition of Dr. Max Sugar may be admitted as a trial deposition.

j. The submitting parties shall give the other parties notice of the contents of their summaries as early as possible.

By the Court:

(s) Daniel H. Huyett, 3d
Daniel H. Huyett, 3d

Dated: 8/21/74

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

[Title omitted in printing.]

EVIDENTIARY HEARING

First Day

Philadelphia, Pa., September 9, 1974
(10:00 a.m.)

Before:

Hon. John J. Gibbons, C. J.
Hon. Daniel H. Huyett, 3rd, J.
Hon. Raymond J. Broderick, J.

Present:

David Ferleger, Esq., Attorney for Plaintiffs, Mental Patient Civil Liberties Project, Philadelphia, Pa. 19107.

Barry Roth, Esq., Assistant Attorney General, Darius G. C. Moss, Esq., Assistant Attorney General, Attorneys for Defendants, Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa. 17120.

(2) (All Counsel and parties being present, the following transpired in open court.)

JUDGE GIBBONS: Mr. Roth, the first item of business I suppose is your motion to dismiss, and I should advise you we have concluded we will take that under advisement and you should proceed with the testimony.

MR. ROTH: Thank you.

MR. FERLEGER: Just for the record, your Honor, I think you have forgotten that I think that was already taken care of in a previous order.

JUDGE GIBBONS: I think it may have been, but I see it is listed.

MR. FERLEGER: I wasn't aware of that.

JUDGE HUYETT: How did we take care of it in the previous order?

MR. FERLEGER: In your April 29th order after our meeting, you asked me to draft the order which allowed the case to be maintained as a Class Action, dropped Haverford Hospital as a Defendant, appointed myself as guardian and denied the motion to dismiss.

JUDGE GIBBONS: Well, it is listed this morning. Whether that is a renewal or otherwise, we will take it under advisement.

Mr. Ferleger, do you have a witness?

(3) MR. FERLEGER: Yes, your Honor.

This morning we have three witnesses to present to the Court, all expert psychiatrists.

The first is Dr. Henry Kandler. He will testify regarding his experiences as a psychiatrist and working with lawyers.

Our other two witnesses will follow.

To save time, rather than making any statement, I'd like to call Dr. Henry Kandler to the stand.

MR. ROTH: Your Honor, if I may, I would like to make some specific requests of this Court and I'd like to do that now if that would be appropriate with regard to—

JUDGE GIBBONS: We cannot tell whether it would be, until we hear the requests.

MR. ROTH: May I be given the opportunity to present them now?

JUDGE GIBBONS: Yes.

MR. ROTH: Thank you, your Honor.

I appropriate this time, your Honor, to present several matters before your Court.

The first being through an oversight, I was under the impression that I had submitted the admission notes of Alan Moss and Donn Dickel. The opposing counsel (4) had submitted affidavits by these two youngsters who are at the Haverford State Hospital and I had spoken to Judge Huyett through his law clerk, Mr. John Langel indicating I would like to introduce into the record the admission notes of those two juveniles.

I am prepared to have Dr. Kratsa, who was the admitting psychiatrist, testify to these admission notes.

I am also prepared to have affidavits submitted by him which I have now. I sent a letter to your Honorable Court on September 3rd, indicating the admission notes of these two youngsters.

I know this has not yet been introduced into evidence by opposing counsel. However, I would like to reserve

that right to introduce these notes in order to further elucidate the position by the Defendants in this case.

JUDGE GIBBONS: Do you have any objection?

MR. FERLEGER: Yes, I do, your Honor.

These affidavits of the Plaintiffs were filed on April 25, 1973, under an order—special order protecting the confidentiality and the rights of the affiants.

Mr. Roth, not only knew about it since 1973, but never mentioned any desire to submit any (5) counter affidavits, either in the pretrial order negotiations or in our meetings with Judge Huyett. I think that once the final prehearing order has been entered that it is improper to suddenly on the day of trial or week before it, to decide that you want to submit counter affidavits.

JUDGE GIBBONS: Do you have any substantive objection?

MR FERLEGER: No. I am sure that the copies of the admission notes that Mr. Roth has are accurate copies.

JUDGE GIBBONS: You may do that and you can have them marked with the clerk and sometime before it is necessary to make reference to them.

MR. ROTH: Fine. I shall admit them now.

We will not be making reference to them in the hearing, your Honor.

JUDGE GIBBONS: We won't take the time. But I charge you with the responsibility of getting them appropriately marked in evidence before it is necessary to make reference to them.

MR. ROTH: Thank you.

I do have several other matters and again, I appreciate your indulgence.

With regard to our regulations which were (6) promulgated and adopted back in September, 1973, we had a hearing in April and I had indicated to the Court at that time how those regulations were being affectuated [sic] and in particular, I indicated a compilation of statistics compiled by Mr. Ralph Phelps of the Office of Mental Health in order to show the Court what was happening in each instance where juveniles objected to subsequent admission.

At that time it was my impression it had been introduced into the record and in order to insure that, I would prefer to introduce that also before your Honor. Again, I had alerted this situation to his Honor Judge Huyett through Mr. Langel last week and I am prepared to have Mr. Phelps come down from Harrisburg in order to testify to his compilation of these statistics.

JUDGE GIBBONS: Mr. Ferleger?

MR. FERLEGER: Your Honor, with reference to that, that was discussed as Mr. Roth indicates and I noted at that time that I had two clients who had objected to institutionalization who weren't listed on that summary so it was clear to me that factually that summary was incorrect with regard to at least two of my clients and I imagine with regard to other people across the state.

It purported to be a summary of all cases across the state in which these new regulations had been (7) involved and I don't see how, especially with non-state hospitals and I know for a fact that two cases are not listed on there, I don't see how this can be introduced into evidence at

all and I really don't see the relevance of it to this Court's proceedings.

MR. ROTH: Your Honors, if I may?

JUDGE GIBBONS: I think he would be entitled to cross-examine. The summary could go in if you had a witness here that he could cross-examine. I don't think it could, otherwise.

MR. ROTH: With regard to Mr. Ferleger's comment, the number of objections had not been listed by individual name. It just had been listed as to the number of objections and how the institutions handled those objections at the time.

JUDGE GIBBONS: I think you had better produce the witness and lay the groundwork for the introduction of the summary, so that Mr. Ferleger can cross-examine and object.

JUDGE BRODERICK: May I suggest something?

JUDGE GIBBONS: Yes.

JUDGE BRODERICK: May I suggest if the summary is corrected there could be an agreement to it, but otherwise, as Judge Gibbons has just indicated you will have to follow that procedure.

(8) MR. ROTH: Thank you, your Honor.

With regard to the prehearing order, we did agree that the Commonwealth would supply the admission profiles, if you will, of ten patients selected by the plaintiffs. I had sent these patients' profiles on to this Honorable Court and to Mr. Ferleger sometime ago and we would like to introduce those into evidence, also.

I have not heard of any objections prior to this time from opposing Counsel with regard to those ten patients' profiles.

JUDGE GIBBONS: Mr. Ferleger?

MR. FERLEGER: I have no objection.

JUDGE GIBBONS: They will be marked in evidence and again, rather than delay the witnesses, I charge you with the responsibility of having them appropriately marked before they need to be referred to.

MR. ROTH: Thank you, your Honor.

Again, thank you for this time.

With regard to our witnesses, your Honor, we had five witnesses and we have narrowed that to four witnesses. We have excluded Dr. Armstrong.

Now, it has been my review of the situation with these witnesses that each witness will take approximately an hour to an hour and a half. Today, we are going to begin with Dr. Tashjian. On Wednesday, we anticipate (9) calling Drs. Masterson, Miller and Gibbs.

Now, with regard to the time limit on Wednesday which will be from 9:30 to 1:00 o'clock, pursuant to your Court order, it would be appreciated if we could continue this for another day—to present Dr. Gibbs.

All these gentlemen are from out of state, Michigan, New York, Baltimore. I am prepared to have Dr. Gibbs come on Wednesday if you so desire. I have alerted Judge Huyett through his law clerk, to this situation.

JUDGE GIBBONS: I think we will have to anticipate only getting through two on Wednesday. Our collec-

tive judgment is that by the time cross-examination is finished, it will be so close to one o'clock as to make it impossible to complete the third doctor and we don't think it is appropriate to have him make two trips.

Therefore, you can assume that we will continue with his testimony on a subsequent date and that closing argument will be held on that same date.

MR. ROTH: Thank you, your Honor.

JUDGE GIBBONS: Monday, October 7, 1974, we will convene at ten o'clock and complete the testimony. Any rebuttal testimony should be presented at that time and we will proceed with closing argument. If need be, (10) we will continue on the 8th of October. We will advise you of the courtroom.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you, your Honors.

Your Honors, with regard to the pretrial deposition of Dr. Max Sugar, that deposition I would like to introduce into the record, also.

Now, I have provided the Court with a rather lengthy summary of that deposition some time ago and last week, I did receive the signed copy—the signed original— of Dr. Sugar's deposition by him and I had advised him, you know, pursuant to Court Rule 30, that he ought to state in an accompanying letter any objections that he had to form and substance.

Dr. Sugar merely changed some words around on the original deposition. He has supplied me with that, but not provided me with reasons. I can assure this Honorable

Court, as well as Mr. Ferleger, that there has been no changes as to substance.

Nonetheless, I'd like to introduce that pretrial deposition, as well as the changes on xerox sheets which I have, and reserve it for Mr. Ferleger's objections.

JUDGE GIBBONS: Mr. Ferleger, any objections to that course?

(11) MR. FERLEGER: No, I haven't seen the corrections and I'd like to.

I might note, just for the record, that Dr. Finer, who was deposed by the court order in this case, I'm still waiting for the court reporter's transcript, because we did not have time for Mr. Roth to finish his questions and he has agreed to submit interrogatories and we hope that will be done by October the 7th.

MR. ROTH: That was my next point.

Hopefully, I will have that done by October 7th. In any event, I will have that certainly done before the record is closed in this case.

With regard to Dr. Armstrong's deposition which was taken, I believe, in March of 1973, your Honors, we have agreed that Mr. Ferleger would underline portions agreed upon and those portions disagreed upon would be admitted into evidence.

I have not yet received that, although I have received several papers from Mr. Ferleger just a few minutes ago and I believe one of those papers does refer to the deposition of Dr. Armstrong. I haven't had a chance to read any of these. However, I just wanted to indicate to the Court that I am agreeable to submitting the deposition of Dr. Armstrong in its entirety, if necessary.

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(12) JUDGE GIBBONS: All right. Again, I charge you to have it appropriately marked. All of these depositions have to be marked in evidence.

MR. ROTH: Fine.

Your Honor, I believe Mr. Ferleger will be introducing that deposition in accordance with our agreement.

JUDGE GIBBONS: If it is your offer, you, Mr. Ferleger, are responsible to having it marked in evidence.

MR. FERLEGER: Certainly, your Honor.

MR. ROTH: With regard to my understanding of what is in the record, specifically, we are requesting that all the interrogatories and answers are in the record and especially the answers to—

JUDGE GIBBONS: Have they been marked in evidence?

JUDGE HUYETT: They have not been marked.

MR. ROTH: No, they haven't. I believe we discussed that at the prehearing conference and I believe we decided they would all be introduced into the record.

MR. FERLEGER: There was no decision to abandon marking them.

JUDGE GIBBONS: They should be marked, (13) because they are not in the record for appeal purposes, unless they have been admitted into evidence.

JUDGE HUYETT: I would suggest that Counsel get together before October 7th and give them the next exhibit numbers so they are marked and then they can be formally admitted into the record. Just because something

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has been docketed and filed, does not make it part of the record for appeal purposes.

MR. ROTH: Thank you, your Honor, we shall do so.

Again, I had spoken to Judge Huyett through Mr. Langel last week, regarding the submitting the biographies of the expert witnesses and perhaps we can arrive at a stipulation with regard to that.

Neither Mr. Ferleger nor I have exchanged the Curriculum Vitaes of the witnesses and it would be my feeling at this point, your Honor, although I'd like to expedite the hearing that perhaps we should hear the qualifications and if your Honors feel we should submit the biographies, we will, but I think it is necessary to hear the qualifications.

JUDGE HUYETT: Are these fairly short?

MR. FERLEGER: Just to let you know what the plaintiffs are doing. You have, I handed up this morning before you arrived, Plaintiff's Exhibit Numbers (14) 1, 2, and 3. Number 1, the Court has already ordered, it may be admitted. Numbers 2 and 3, the Court has given us permission to submit them here this morning.

Dr. Leon Ginsburg, as I explained to Judge Huyett in a paper filed, he is in South America. The affidavit has been filed for more than a year, I believe, although Mr. Roth has told me that he did not get it when we originally sent it out.

Exhibits 4, 5, and 6, are the resumes of our expert witnesses and I would move, maybe to expedite things, for the admission of all of our Exhibits at this time.

JUDGE GIBBONS: Move the admission of each Curriculum Vitae as the witness is on the stand, so it appears in the same part of the record.

JUDGE HUYETT: Are they too long to read?

My thought is to save time and if the Curriculum Vitae is short it could be read and this would be supplemented by a few questions, rather than going through a long procedure of questions and answers.

MR. FERLEGER: What I was anticipating was having my witnesses describe the most salient points of their qualifications and leave a lot of the listings of articles and talks to the written material.

JUDGE GIBBONS: Just mark the Curriculum (15) Vitae as each witness gets on the stand and present those highlights that you think are appropriate by question.

MR. FERLEGER: I will, your Honor.

JUDGE GIBBONS: Anything else, Mr. Roth?

MR. ROTH: Yes, your Honor.

With regard to my brief which was submitted about two weeks ago, I would just like to note a correction on page 22 and it appeared that the citation of Logan versus Arafeh, that should be Volume 346, your Honor. I'm sorry for that.

Your Honor at this time, that is all I have. Thank you again.

MR. FERLEGER: Dr. Kandler.

HENRY O. KANDLER, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Dr. Henry O. Kandler.

Direct Examination

BY MR. FERLEGER:

Q. What is your address?

A. My office is 124 East 84th Street in New York City.

Q. What is your occupation?

A. I am a psychiatrist.

Q. Would you please give to the Court briefly your (16) current affiliations or appointments?

A. Yes.

I am Assistant Clinical Professor of Psychiatry at the Albert Einstein College of Medicine and I am Associate Attending Psychiatrist at the Bronx Municipal Hospital Center.

Q. Have you been associated with any hospitals in the state hospital system?

A. Yes; for a period of five years I was Supervising Psychiatrist at Bronx State Hospital.

Q. What are your current responsibilities at the Albert Einstein College of Medicine?

A. Right now I am Associate Director of Adolescent Psychiatry at both the medical school and hospital.

Q. What do you do in that capacity?

A. Primarily, I supervise trainees, fellows and residents who work in the clinic right now and I am also in charge of the school consultation program and have some administrative duties as far as the clinic is concerned.

Q. For how long have you been involved in the area of child psychiatry or adolescent psychiatry?

A. For 16 years.

This clinic job is a new one for me. For the past 16 years, I have been involved in in-patient psychiatry.

(17) Q. What facilities?

A. At the same facilities that I have mentioned.

Q. Can you estimate the number of children involved that were under your responsibility or supervision?

A. We admit somewhere between 60 and 100 adolescents a year, depending on how those services were set up.

I was usually, during this period of time, in charge of one ward. So that would be about one-third of them. So, I estimate that I have been in perhaps direct charge of 400 adolescents who have been admitted to our hospital.

Q. Do you work with children or families of children in your private practice?

A. Adolescents, yes. Not younger children.

Q. Dr. Kandler, you have seen the Curriculum Vitae that you gave me and it is now in the Court's hands.

Is that an accurate summary of your qualifications and background?

A. Yes.

MR. FERLEGER: Your Honors, I'd like to move for the admission of Plaintiff's Exhibit Number 4.

JUDGE GIBBONS: Number them in sequence as to whatever the next plaintiff's number is.

JUDGE HUYETT: Were your Exhibits 1, 2, and 3 admitted at the prehearing conference?

(18) MR. FERLEGER: Yes. Exhibits 2 and 3, your Honors ordered we'd be allowed to submit for a ruling today.

JUDGE HUYETT: Where are Exhibits 1, 2, and 3, physically? Have they been marked?

MR. FERLEGER: Exhibit 1 has already been docketed and filed. Exhibit 3 has already been docketed and filed and Exhibit 2 has been docketed and filed, as well.

MR. ROTH: If I may, your Honor, as I recall the Exhibits were disagreed upon in our statement of facts and it is up to the Court in order to determine the probative value today.

MR. FERLEGER: Except for Number 1. Number 1, Judge Huyett ordered admitted.

JUDGE HUYETT: Where is there a reference to these in the prehearing order?

MR. FERLEGER: In your order issued after our last conference, at paragraph 3(f), your Honor ordered that plaintiff's Exhibits 2 and 3 may be offered at the hearing and the Court will determine their admissibility and weight.

MR. ROTH: Exactly. In that order, it does not say anything about Exhibit 1. It was my understanding that this Exhibit was not admitted.

(19) JUDGE GIBBONS: Let's not talk about Exhibit 1 at this point. Let's get a number for what you referred to as "Exhibit 4."

The previous Exhibits have been given numbers 1, 2, and 3 in the prehearing order and this will be

marked Exhibit 4 which will be admitted in evidence.

Give the Clerk a copy for the Court to file.

(Whereupon, the Curriculum Vitae of Dr. Kandler was marked Plaintiff's Exhibit 4 in evidence as of this date.)

MR. ROTH: I do have some questions with regard to the witness' qualifications.

JUDGE GIBBONS: You may examine now on his qualifications.

MR. ROTH: Thank you, your Honor.

MR. FERLEGER: Your Honor, if Mr. Roth is just going to question with regard to the extent or stature of his qualifications, I think he should hold that for cross-examination, but if he wants to question—

JUDGE GIBBONS: He may examine on his qualifications at this point.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you.

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(20) *Cross-Examination*

BY MR. ROTH:

Q. Dr. Kandler, would you please indicate to me if you are Board certified in general psychiatry?

A. No, I am not.

Q. Are you Board certified in child psychiatry?

A. No, I am not.

Q. Are you Board eligible in general psychiatry?

A. Yes.

Q. Are you Board eligible in child psychiatry?

A. I am not sure—I think you have to have the general first.

Q. Can you please explain the difference between Board eligibility and Board certification?

A. The difference is taking an examination and passing it.

Q. Is it not true, Doctor, that Board certification indicates an acceptable level of expertise in that area of psychiatry?

A. I personally don't believe so.

Q. Does not that Board certification indicate what I just revealed to you?

A. I don't believe so, no.

MR. ROTH: Your Honor, at this time, I will reserve questions with regard to his experience (21) and history in general and child psychiatry for cross-examination.

Continued Direct Examination

BY MR. FERLEGER:

Q. Dr. Kandler, as you know, this lawsuit involves the rights of children to have pre-mental commitment judicial hearings. That involves the relationship between the law and psychiatry.

Have you had any experience with lawyers being involved in commitment proceedings and can you describe that experience?

A. Yes, rather extensively.

In New York State for several years now, we have had a mental health information service, which was set up by state law and which is an arm of the Court that is responsible for commitment proceedings and under this program, every hospital has a lawyer or there are lawyers responsible for several hospitals if the service is small, who is available to all patients—all patients, that includes children, adolescents and adults, to discuss with them their rights and to help them with any complaints they have about being in the hospital.

Q. Have you had contact as a psychiatrist with one of these lawyers for your patients?

A. Yes, extensively.

(22) Q. Do you have any opinions regarding the benefit or disadvantage to those juvenile patients of such contact with attorneys?

A. I think it is proven over the years to be an advantage. The advantages are several-fold.

First of all, it relieves the psychiatrist from wearing two hats, from both having to be responsible with seeing that a patient is apprised of his rights and explaining something that he is not an expert in while at the same time being a psychiatrist.

I think it leaves him free to make a reasonable judgment and recommendation to a patient about hospitalization and treatment without at the same time having to say, "However, if you don't agree, you can go to Court and have this reviewed."

I think at the same time it provides for better legal advice for the patient, because there is an expert who is well versed in these rights advising the patient.

Q. Do you feel that your treatment of juveniles is hindered at all by the juveniles being represented by an attorney?

A. Not at all. I find it helpful.

Q. In cases where there is a disagreement about the need for treatment, do you find that the adversarial (23) stance of the lawyer ever interferes with the best interests of the juvenile?

A. I haven't found it so. I think what happens is that it does not come to a hearing. I think the mere fact that that possibility exists leads to both from the legal point of view and from the psychiatric point of view, the best compromise solution being found to help the patient.

Q. Dr. Kandler, I wonder if you would give us your opinion regarding the reliability of parents of possibly disturbed youngsters as the source of information with regard to commitments?

In other words, do you think that parents should be relied upon to make applications for the commitment of children?

A. Well, I think some parents are reliable and some parents are less reliable.

Some parents are very angry at their children and would like to have the children placed somewhere else and some parents are honestly mistaken in their judgments.

So I think you get a whole panorama of possibilities.

Q. Do you feel that there would be any advantages from a prior judicial hearing for the commitment of a juvenile (24) in a non-emergency situation?

A. I think the advantage is an indirect one.

In a sense that when the possibility of a hearing exists, then those agencies or people that consider that it is in the best interests to have the child placed in a hospital,

have to make sure that the child or adolescent is thoroughly worked up and the case is thoroughly understood and there is an agreement it is in the best interest of the child.

The advantages, it makes a better situation beforehand, putting everybody on notice to do a better job.

Q. Are there any therapeutic aspects to the child in having a hearing or representation by Counsel or an advocate?

A. I think there are two.

First of all, I think what happens is that rather than arbitrarily railroading a child into the hospital, the situation has to be explained to the child very thoroughly and this also goes on once the child is in the hospital that the staff makes an effort to try to explain to the child why he is there and why it is necessary for him to be in the hospital and what type of treatment his is getting and I think that makes a better treatment.

(25) In psychiatry it is difficult to treat a patient without the cooperation of the patient and even at times during an emergency situation one has to admit a patient quickly against his will. Nevertheless, eventually, you need the cooperation of the patient. Even if it is only as simple as taking medication, if the patient leaves the hospital and discontinues taking the medicine it is harmful. Especially in the case of psychotherapy.

The second advantage is it gives the child a sense of trust and responsibility, because he has some other alternative. He can go for advice to someone who is an expert, who may either advise that the child cooperate in the treatment or suggest that the child have a hearing and try to get out of the hospital.

Q. I understand that in New York, as the law is in the City of New York, the hearings are on a challenge to a commitment once it's been accomplished.

Do you see any reason why your comments would not apply to the treatment situation as well?

A. In general, no. There are emergency situations in psychiatry and there must be some procedure by which one can safeguard the patient from harming himself or other people when the situation is one of immediacy.

Otherwise, I think it would apply.

(26) Q. You are generally familiar with the emergency provisions of the Pennsylvania Mental Health Law.

Do you think—

JUDGE GIBBONS: Wait a moment.

Ask him, is he, first.

Q. Dr. Kandler, are you familiar generally with the fact that Pennsylvania has emergency provisions for commitment procedures?

A. I know they do.

Q. Do you feel those procedures are generally adequate for the emergency where—

A. I don't know the details enough of the Pennsylvania law.

Q. Thank you.

Dr. Kandler, would you please explain whether or not you feel there are differences between institutional, inpatient juveniles in a psychiatric facility as opposed to outpatient care or general medical care, differences which merit a prior hearing?

A. Well, I certainly do.

I think when you lock someone up, you deprive him in large measure of control of his life and I think this ought to be done carefully.

Q. Dr. Kandler, do you know whether there are any national medical or psychiatric standards regarding the (27) provisions of legal counsel for due process to children?

A. Probably the most pertinent one is in the latest accreditation manual for psychiatric facilities serving children and adolescents.

Q. Who published that or wrote that?

A. This is published by The Joint Commission on Accreditation of Hospitals.

Q. Who are they?

A. This is an organization that was formed over 20 years by the American College of Surgeons and Physicians and The American Hospital Association and The Medical Association and Their Approval of Hospital Facilities. In this instance Psychiatric facilities for children very often determines whether they get funds and is certainly involved in their getting federal funds and let me quote, they have several sections—

JUDGE GIBBONS: Mr. Ferleger, before the doctor refers to this document, will you have it marked for identification?

MR. FERLEGER: Certainly, your Honor.

(Above referred to manual entitled, "Psychiatric Facilities Serving Children and Adolescents," was marked plaintiffs' Exhibit 7 for identification as of this date.)

JUDGE HUYETT: What is the exact description?

(28) MR. FERLEGER: That is the "Accreditation Manual Serving Children and Adolescents," copyright number 1974, and paid for by a grant from the National Institute of Mental Health.

I think that a reference to the law regarding Medicare and Medicaid provisions will show that these standards are adopted by the Congress as the standards of Medicare and Medicaid aid to Hospitals.

JUDGE GIBBONS: Have you seen it, Mr. Roth?

MR. ROTH: I have only seen it briefly.

Of course, it is not being introduced into evidence. So we reserve objection to that, your Honor.

Continued Direct Examination by Mr. Ferleger:

Q. Are these standards generally accepted by child psychiatrists and proper standards for care of children in facilities?

A. Yes, and throughout this they make a distinction between the standards that shall be made and those standards that ought to be met. So, it is both a standard, plus a guide for the kind of improvement that should be implemented.

Q. What do they say with regard to due process and legal advice for children?

A. "The psychiatric facility serving children (29) and adolescents shall know the dignity and protect the rights of all its patients and their families. Every effort shall be made to safeguard the legal and civil rights of patients and to make certain that they are kept informed

of their rights, including the right to legal counsel and all other requirements of due process when necessary."

Let me add the reason I became involved with this, because I am setting up a day hospital at this moment and as a part of the budgeting for that facility, there is the budgeting for an attorney involved to provide the help to children in this facility?

MR. FERLEGER: No further question.

JUDGE GIBBONS: Are you going to offer that document?

MR. FERLEGER: No, I am not, your Honor.

JUDGE GIBBONS: All right.

Mr. Roth?

MR. ROTH: Your Honor, would you indulge us for just a moment, please?

JUDGE GIBBONS: Yes.

MR. ROTH: Thank you.

Cross-Examination

BY MR. ROTH:

Q. Dr. Kandler, would you please indicate what experience (30) you have and the duration of that experience in admitting adolescents?

A. I have been affiliated with the in-patient services of Bronx Municipal Hospital Center for 16 years and while being on that staff I was for five years supervising psychiatrist at Bronx State Hospital.

Both of these facilities are run by the Albert Einstein College of Medicine, so it is possible to have responsibilities in both areas.

Q. Would those facilities be considered an institution?

A. I'm not sure of the medical definition of institution. Certainly the State Hospital would be considered an institution. The other is a city hospital with a large psychiatric facility.

Q. The ones you work with are the city hospitals?

A. And for five years a state hospital.

JUDGE GIBBONS: Both in-patient facilities?

THE WITNESS: Yes.

Q. What was your role at the institution when you worked there for five years, were you the admitting psychiatrist of adolescents and juveniles?

A. I was first of all assistant director of a 3-ward unit which we used for training purposes for our residents. As such, there were five residents on my ward. I was responsible for the ward and I supervised them with all (31) their cases on the ward.

Now, in that particular instance, we didn't do particularly the admission, but when they were referred to us, we screened them. In other words, they would have often been at the city hospital and we would select them as being appropriate for this facility for their treatment. So, it was a selection process, rather than an admitting procedure. They were rarely admitted directly to the service, although at times they were.

Q. Do you believe in institutionalization?

A. I don't understand the question. In what regard?

Q. Well, in the sense, Doctor, that you testified with regard to out-patient treatment as well as in-patient.

Do you believe placing one into an in-patient residential facility, and in the State of Pennsylvania, a state mental hospital?

A. I think there were instances where patients have benefited from hospitalization.

Q. Now, Doctor, with regard to some statements you made, you indicated that a lawyer should see a juvenile; is that correct?

A. I think it is very helpful, yes.

Q. When do you think the lawyer ought to see the juvenile?

A. Well, I think there are two instances.

One is before someone is hospitalized and (32) one is after.

I think before one has to be very careful to be able to admit a patient quickly when a patient is in danger of hurting himself or someone else. There has to be some emergency way of taking care of someone who is in acute psychological difficulties. It is something that has to be planned and if there is an objection by the child, I see no reason why this could not be done before hospitalization.

Now, what happens is that one of the problems with psychiatry is that its prognosis is difficult and certainly predicting future behavior is most difficult, so I think it is very important after someone is admitted that legal help be available to someone after they are in the hospital.

Sometimes somebody is upset for a couple of days and then they improve and in a time like that if they are not easily discharged, they ought to have some recourse available.

Q. With regard to the manual which you read parts of on accreditation standards and recommendations, did that manual indicate if a hearing should be held for a juvenile prior to admitting into an in-patient residential facility?

A. Not that I recall.

Q. Doctor, would you please explain the admission (33) procedures there, with regard to juveniles?

Let me be a little more specific.

May a juvenile be admitted by a parent in New York?

A. Only a doctor can admit a patient to the hospital.

Q. May the parent make application for admission of the juvenile to the hospital after the doctor has recommended hospitalization?

A. Yes, they may.

Q. Is there a hearing afforded to a juvenile prior to his hospitalization?

A. Well, that's an interesting question.

It is not excluded, but I have never come across it in the order of events of admission.

Q. Well, Doctor, let me ask you this:

You have testified with regard to the admission procedures in New York in some terms and I am just asking you, do you know from your experience, if it is in fact in law that a juvenile is given a hearing prior to admission?

A. He is not given one, but I think—I personally think, it would be possible for a child to ask for one under the way that I read the law, but this is not my area of competence.

Q. Doctor, do you feel qualified upon evaluating a (34) young person to recommend a treatment for him or her or to recommend in-patient residential care?

A. After my evaluation, yes.

I may want other people to help me in that evaluation.

Q. Do you feel you need a corroborating opinion before placing a youth into any program?

A. Not necessarily. No.

Q. When a juvenile comes to you and I would assume—

MR. ROTH: Strike that, please.

Q. Let me ask you this.

Does a juvenile who needs help, let us say, come to you generally through his parents?

A. That would probably be—with his parent, not necessarily through his parent.

Q. With his parent?

A. Yes.

Q. When the parent and juvenile—

A. I mean, I want to elaborate that.

Very often it may be the child's wish to see someone and the parent acquiesces. Our problem is treating children who want treatment without the parents' knowing, not the other way around.

Q. When the parent is before you and the juvenile is before you, do you formally evaluate the juvenile?

(35) A. As well as the parent.

Q. Do you feel in some circumstances, it is important to review the parents?

A. Nearly always.

Q. Now, Doctor, how important is the family structure in terms of the development and growth of children?

A. What do you mean by "family structure"?

Q. For example, you have testified that some parents are reliable and they bring their child to an institution and you observe their behavior pattern and you testified that some are not as reliable and some are unreliable, and I am questioning how important is the family structure in terms of allowing the parent to seek this type of help for their juvenile—for their child?

A. I am still not sure of what you mean by "family structure".

Q. Doctor, I will take it from another avenue and I think it will clarify it more.

Do you think that parents generally operate in the best interests of their children?

A. Generally.

Q. Do you think that parents have a callous disregard for their children and are merely attempting to plop their children into institutions?

MR. FERLEGER: Objection as to the phrasing (36) of the question.

JUDGE GIBBONS: Overruled.

Q. Please answer the question.

A. It happens. I think the majority of parents have the best interests of their children at heart.

I think mostly where I am concerned about the issues that we are talking about here is—

Q. Doctor, I am sorry to interrupt you. I'd like—

JUDGE GIBBONS: That is a responsive answer.

A. I think some parents callously would like to get rid of their children, though the biggest number of chil-

dren who may not get the best possible treatment occurs where there is ignorance on the part of the parent.

Q. I'm sorry, I didn't get that.

A. "Where there is ignorance on the part of the parent."

Q. Do you feel there would be a conspiracy between parents and physicians and psychiatrists to place children into institutions?

A. No, I don't think so.

Q. Doctor, do you feel that most parents don't want to be separated from their children?

A. Most parents do not.

Q. Do you think that parents who have economic means and are able to doctor-shop in order to obtain treatment for their child without recommendations for institutionali (37) zation are better equipped as parents than those who come from poor socio-economic backgrounds and cannot doctor-shop?

MR. FERLEGER: I object to the question.

I don't understand the question, myself.

JUDGE GIBBONS: Do you understand it, Doctor?

THE WITNESS: I think I understand what he is driving at.

JUDGE GIBBONS: Objection overruled.

A. I don't think the variable is money. I think the variable is knowledge.

There may be some slight correlation between education and money. However, I think very few of us, when we are in trouble seek a second opinion. I think this is

a problem that is generally true. I think the population at large isn't discriminating enough in selecting all of their physicians.

Q. We are talking about the education and awareness of parents of meeting their children's needs, I would assume, and would you not feel that parents who perhaps may have a bit more education and are able to afford, if you will, more expensive treatment, generally doctor-shop, not necessarily to find one who will recommend institutionalization, but in order to find an evaluation (38) where they will not have to be separated from their child?

A. I think people doctor-shop to find a physician that agrees with them and that may be right or it may be wrong.

Q. Doctor, under—

A. As a matter of fact, there is a study that people overweight tend to go to doctors overweight.

And I think the same thing is true in psychiatry, that there are so many modalities of treatment that people try to find somebody who agrees with their opinion.

Q. Isn't that precipitated by the fact that parents do not want to be separated from their children?

A. That is not the issue at this juncture.

I don't think that that issue comes up. I think if they think about it at all, they are more likely to think they can't handle the situation, rather than worrying that the child would be forcibly taken away from them.

Q. Are you familiar with the procedure of parents making application for their children in Pennsylvania?

A. Somewhat.

Q. Would you please explain what you think the situation is for voluntary admission of children by parents?

A. The parent can petition to have the child institutionalized.

(39) Q. Do you know what the safeguards provided are for the screening of the child prior to institutionalization?

A. Prior to this case, there were none, but since this case, regulations have been set up that children from 13 to 18 can have legal advice, but there are no provisions for children under 13.

Q. Doctor, I do not think you have been totally informed about the safeguards.

With regard to juveniles, in order to get your opinion on whether or not this procedure is acceptable to you as a professional—

A. Juveniles at what age?

Q. It refers to youths from age zero to age 18. We are not restricting ourselves to juveniles or adolescents, but any juvenile 18 and younger, whether he is mentally retarded or mentally disabled may not be admitted to an institution until he is referred from a recognized medical facility, mental health, mental retardation therapist or mental health agency—

MR. FERLEGER: Mr. Roth is reading from the regulations and I must object.

JUDGE GIBBONS: He is laying the groundwork for a question and don't object until he asks the question.

MR. FERLEGER: His necessity to read it may also necessitate that Dr. Kandler have it in front of (40) you in answering the question.

JUDGE GIBBONS: Bring it up and let the witness look at it.

MR. ROTH: May we have a moment, please?

JUDGE GIBBONS: Are you referring to annex "a" to title 55?

MR. ROTH: Yes, I seem to have it attached to something—

JUDGE GIBBONS: I have handed him our copy.

Q. Can we look at page 1 and under numbers 1 and 2, it indicates how juveniles are, if you will, reviewed prior to their ultimate admission into an institution and in a form of summary, what basically occurs is that there is a referral unit and that referral unit be an individual therapist or a base service unit in Pennsylvania who will evaluate the child and we assume total evaluation of family, et cetera, in order to come to a disposition of whether or not the juvenile or child should be afforded admission into an institution.

Subsequently, the parent takes that child to the institution which is recommended by the referral unit and the director at that institution causes an individual examination to occur.

Now, at that point, if the individual examination corroborates the first, then admission is (41) made of the juvenile by the parent.

Now, do you think, since you have already testified that you feel confident to make a recommendation to either institutionalize or recommend mental treatment for a juvenile, do you think their screening devices are appropriate?

MR. FERLEGER: Objection, your Honor.

The question is not making recommendations. Dr. Kandler had not been asked whether admission should occur on a recommendation of his or anybody else's.

We don't question the right of referral agencies to make recommendations. All we question is who the decision maker should be.

JUDGE GIBBONS: Overruled.

You may answer the question.

A. The procedure sounds very good on paper, but unfortunately, there is a large gap between outlined procedures and the quality of the kind of evaluation the patient gets and my concern is with that quality.

I don't know the details of what the examination consists of. It isn't spelled out at all in this regulation. It can be a five minute chat with someone. I think it is good as far as it goes, but the only way for me to judge whether the procedure is good, I would have to know the people who are making the (42) examination, what kind of tests are done and so forth.

Q. Well, Doctor, assuming—now, assuming that the evaluation is done according to, if you will, generally accepted principals in psychiatry, would that satisfy you?

A. It would satisfy me.

I would have one worry about it and that is even carefully done psychological evaluations, the prediction of behavior is rather limited. People change and an evaluation takes a couple of months and it takes another month to get someone into an institution and there might be a vast change in an adult or child for that matter and I don't think it is enough for this evaluation to have taken place before hospitalization.

I think after hospitalization, equal care has to be taken and there must also be alternative judgments available after one is hospitalized, especially one which deprives one of his freedom.

Q. This case does not involve the right to treatment. The plaintiffs have not made any allegation that treatment is not being afforded to juveniles—

A. I was talking about keeping somebody institutionalized. I think that should be reviewed periodically.

Q. Doctor, without going far afield, that is a necessary part of treatment.

(43) Do you not evaluate as part of your treatment process, a person prior to his admission to a facility as well as subsequently?

A. I do.

Q. Don't you consider that part of the treatment process?

A. Absolutely.

Q. Now, assuming again, Doctor, that although on paper, we do not have outlined what one must do, a psychiatrist or a base service unit or anything of that sort in order to evaluate a juvenile, but recognizing them for acceptable facilities, do you feel that that two-step process is acceptable to you in terms of the recommendation that may be made to the parents as to whether or not the child does need institutionalization?

A. It is difficult for me to answer that directly the way you put the question.

I know from experience that even though there are regulations that the criteria for admission to an institution varies widely from city to city. I know that is true in New York City.

It is better when you have more than one judgment. No institution ought to be forced to treat someone who they don't think belongs in the institution and therefore, the director or his delegate should judge (44) whether somebody ought to be in his facility.

It is hard for me to say this is adequate because so much depends on how this is done and I know from experience that the statistics for admission to equal facilities within the same area vary widely.

Q. If you felt that parents and physicians and psychiatrists are acting in sort of a conspiracy to place children into institutions and as I recall—

A. I found no conspiracy between the three of them.

I think at times families cannot handle their children and try everything possible to get people into a hospital without necessarily relying on expert advice and I think most of the difficulty comes because unfortunately, there are nowhere near adequate facilities to take care of those people who need to have care.

There is not enough staff to do the job the way it ought to be properly done and things are slipshod.

Q. Do you feel for example, yourself, as a professional, if I were to come to your place and if I had a child and brought that child to you and you evaluated the child and the child did not need institutionalization and I said, "I really want this child in your institution," would you put the child in the institution?

A. No, the parent would take the child to someone else, (45) presumably someone more prone to institutionalizing of children.

Q. Along with those procedures, we do have a procedure and again reading down the page and particularly,

I alert you to number 6, we do have a procedure where every juvenile, age 13 or older, is given notice of the reasons for his admission and he is provided with a telephone number of the person who made application for him, which, by the way, Doctor, is limited to a parent, guardian, a person standing in locus parentis and he will be afforded counsel if he objects subsequently to admission and you have testified according to your law, there is no law indicating a juvenile must be given a hearing prior to admission and that the J.C.H. standards do not indicate this should be done.

Do you think a juvenile should be afforded this type of procedure?

A. Here it states, "13 or older." It eliminates younger children and I would disagree with that, and, secondly, excepting emergency children, it is a dangerous thing to remove a child from his environment and family and so forth and I think if there is serious conflict between the parents involved, including objection from the child, I think the child ought to have some representation, whether it be a psychiatrist or lawyer of his (46) choosing and I think this will help the children at a future time, if the child is convinced that what is being done for him is in his interests rather than anyone else's. I think it will help treatment in the future immeasurably.

JUDGE GIBBONS: Doctor, you indicated that you disagreed with the cut of age of 13 for notice purposes.

Do you have an opinion as to at what age a notice provision would be meaningful?

THE WITNESS: Well, I thought about that question.

It is difficult for me to answer that. Thirteen is not a bad breaking point, because we arbitrarily divide adolescents and children. I think younger children need protection and I have been in contact with the deputy director of our Mental Institute Division and they are concerned about that because they are less able to make decisions and ask for help and they consider it a specific duty of theirs to look in on the situation in our children's ward.

As to the actual notification of a piece of paper, that would be an adequate breaking point, but some representation for these children should be made.

They are less able to object, to be able to get a second opinion.

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(47) *Cross-Examination Continued*

BY MR. ROTH:

Q. Doctor, with regard to the advantages of having a hearing prior to the admission of a juvenile, as I understood your response to that type of question from opposing Counsel, you felt that it is better to treat a child who is cooperative, rather than one who is uncooperative; is that correct?

A. Absolutely.

Q. Do you feel that by providing a hearing, where a judge might order a child to be institutionalized, that that is going to affect the child's attitude in cooperating with treatment?

A. It would be better if that were not necessary, but at times, rarely, but at times, a child has to, or an

adult for that matter, has to be institutionalized in order to begin the treatment.

The purpose of treatment is to make the child cooperate with the treatment.

In New York State, we specifically request—we are requested by the Mental Health Law that we reduce the degree of institutionalization. It is not good to have someone, except for an emergency situation, to be admitted against their will.

Q. Doctor, in your experience, do you feel that generally adolescents will not tell you when they are depressed (48) because they wish to avoid the entire affair?

A. Adolescents take a different form than adults.

I am not so sure that few of them complain. They won't call it depression. I think adolescents complain and complain a lot. Perhaps they complain more than adults. The form of their complaint will take other forms. Complaints about authority and school and parents and so forth. They will less rarely come in and say they are depressed, because depression as we know it in adults is something which really occurs more frequently with adults.

Q. Is it not true that juveniles have a reputation as being unmotivated for treatment?

A. I do not find it so.

Q. You do not find that juveniles resent authority and constantly are rebelling to types of authority?

A. To authority, yes. I think that is a part of growing up.

Q. Do you not feel that being admitted into any facility is a type of authority?

A. Well, that depends whether you do it voluntarily or not. The true sense of the word, not the way the law in Pennsylvania defines it.

Q. Do you know of any juveniles that really like the idea of going into an in-patient residential facility?

(49) A. Absolutely. In our wards we have more trouble discharging patients than bringing them into the hospital. They want to stay.

Q. Do you find that juveniles who are objecting are really not objecting in the sense of you and I saying, "No, I don't want to do something," but it is really a so-called plea for help in which they want somebody to help them?

A. That is sometimes true.

Q. Now, one thing I don't want this Court to be misled with, Dr. Kandler, and that is the fact that every child is recommended for institutionalization.

Now, don't you feel, for example, in your practice, what percentage of juveniles or children, rather, come to you do you not recommend for in-patient residential treatment?

A. In my private practice, it is very, very rare.

Our statistics at Jacoby Hospital—first of all, adolescents, some 30 to 40 percent of our adolescents that come to our service come from a Family Court. Out of the remainder, we admit between 20 and 30 percent.

So that means that 60 percent, 70 percent would be referred elsewhere—those that appear in our emergency room, 70-80 percent, rather would be referred (50) to your clinic or some other social agency. Twenty to thirty percent of those coming to our emergency room are admitted. Other facilities, however, this may be double that number.

Q. Doctor, with regard to the section we are discussing, we are talking about non-emergency commitment.

Now, you have already testified that you have some knowledge of the emergency commitment provisions in Pennsylvania.

A. Yes.

Q. Do you feel that every juvenile is a potential emergency situation?

A. Absolutely not. Every juvenile where?

Q. That is being admitted to a facility.

A. There are different facilities, different situations, different hospitals. I can't answer that.

Q. For example, I believe Mr. Ferleger indicated to you that a hearing is provided for an emergency commitment?

MR. FERLEGER: I did not.

MR. ROTH: Strike that.

I'm sorry.

Q. With regard to the 405 Commitment Section, it deals with an emergency provision and states, "One is dangerous to himself and others and can be detained without a (51) hearing—"

A. Yes.

Q. —I am asking you, with regard to juveniles, although their situation may not appear to fit those needs—to fit those limits, if you will, "being dangerous to self or other," do you feel, Doctor, that a juvenile may be a potential emergency situation if help is not given right away?

A. Are you asking whether a situation would get worse if someone is not admitted, even though if it is not an emergency?

Q. If he is not immediately treated.

A. That is possible, but he can also get better.

I have known instances where hospitalization has been put off and the need for hospitalization has disappeared.

Q. Don't you feel it could be traumatic for a juvenile to be in a hearing and all sorts of facts coming out about his need for institutionalization are before him?

Don't you think that could be traumatic for a juvenile?

A. It can be, but my experience has been that it is helpful for the patient to know what other people think of him, including diagnosis.

Q. Doctor, with regard to the entire procedure, where, (52) from my understanding, your recommendation is that a hearing occur prior to institutionalization, do you not feel—

A. I recommend it ought to be available. I think it ought to be avoided if possible, but it ought to be available.

Q. In other words, if there is a conflict between the juvenile and the parent, do you feel that a hearing should be given?

A. I think a hearing should be available to the person who objects to being hospitalized.

Q. Do you find any problem with giving that hearing after the person is hospitalized?

You know, precipitating—

A. I think hospitalization is a very serious affair and unless it is an emergency situation, this possibility ought to exist before.

I am interested in forcing the system to have proper care beforehand so a hearing won't be necessary, so all parents can come to the conclusion what is the best treatment for the patient.

Q. Let's assume that we use the safeguards we have in Pennsylvania, where somebody is screened at step one, the parents are evaluated and the child is evaluated and there are recommendations made to the parent and child, (53) unfortunately, the recommendation, if you will, cannot be anything other than institutionalization and then we go to step 2 and the child and parents are again evaluated by the psychiatrist and the recommendation is made that the juvenile should be admitted into the facility and the child is screaming bloody murder, he does not want to go, and do you feel at that time that the child should be permitted to be institutionalized by the parent and if the child continues to object, then he can be afforded a hearing and in accordance with what you said, all the processes, do you feel the legal processes have been satisfied?

A. By the definition, emergencies ought to be admitted and non-emergencies can wait.

There is no reason to make a decision about a child that may affect him immediately for months and years and perhaps for his lifetime. That decision does not have to be rushed into. I don't see why if you take two safeguards, you can't take a third.

Q. In other words, on one hand, you are saying that a hearing should be given and—

A. I think a hearing ought to be available if the parties concerned can't agree upon what the best treatment for this child is and that would include the child.

Q. When you say, "Parties can't agree," whom do you (54) mean by "parties"?

A. Primarily the child, of course.

Q. So, you feel that a child that is, let's say five years old, is well enough aware of his situation that he can even make a recommendation or a statement as to

what kind of treatment or where he should be placed; is that what you are saying?

A. I think a five year old child that complains of pain, I think it ought to be considered seriously. I don't think he is necessarily right, but he has a right to have someone look into that situation, whether it is a physical pain or mental pain.

Q. Don't you think that pain is being looked into by the psychiatrist?

A. Yes, but we all make mistakes.

Q. Are you telling me that psychiatrists make a large number of mistakes with regard to recommending any treatment programs for a child?

A. I don't think it is large, but I think it is considerable and if it is you, I think it is very important.

Q. Do you make a lot of mistakes?

A. I hope not. I have made some.

Q. Now, Doctor, how essential do you think the role of the family is in terms of having a parent admit his child? Do you think that it is important for the parent (55) to be able to admit his child after he has received recommendations from phase 1 or phase 2, that is, the two steps, if you will, that is recommendations by professionals that the patient be institutionalized, do you think it is proper for the parent to be able to admit the child at that point?

A. Yes.

Q. Doctor, do you feel—

A. I mean, it is important, but as I said before, if it is not an emergency procedure, it is not so important that one need to ignore a child's objection.

Q. Aren't there ways of dealing with a child's objection, other than having a hearing prior to admission?

A. I hope so. The best situation is to get a child to cooperate with the treatment and believe in the treatment.

Q. Let's assume this: Say a parent—you just testified that the parent should be able to admit the child at that point.

What if the child objects to that?

A. You didn't ask me that.

Q. I am asking you that now.

What if the child objects to the parent admitting him?

A. I think the child ought to have someone that he feels is on his side, some professional, whether it be (56) a psychiatrist or attorney, if it is a legal question.

Q. I asked you before if you felt parents operated in callous disregard of the best interests of their children and you said that parents are [not] really operating in disregard for their children's interests.

A. I don't think I can make a general statement like that. I think it happens at times. I think the instances that mostly come to my attention where there are good intentions, but bad results.

Q. So then, Doctor, would it not be fair to assume that if there are abuses of this sort occurring, that perhaps, the way to deal with those abuses is to make sure that the evaluating psychiatrists are not, if you will, making errors in terms of evaluating the parents and the juvenile?

A. There is no question that we should have more psychiatrists and the best possible trained psychiatrists and unfortunately that is not true now.

Even the best psychiatrists make mistakes and there have to be secondary opinions available in medicine as there are appeal provisions available in the law.

Q. Doctor, what we have here is we have already two psychiatric opinions, if you will, in step 1 and step 2 and let's say the child—would you recommend another (57) psychiatric opinion?

How many psychiatric opinions would you recommend prior to admitting a child into an institution?

MR. FERLEGER: I object.

He already testified that he thinks a legal hearing is the best thing and I think this is getting redundant.

A. Well, I will add something to that.

JUDGE GIBBONS: One moment. Objection overruled.

A. It is very difficult to talk numerically.

What I am most concerned with is that the child have someone that he feels is there for his interest and not for his parents' interest or some school interest or social agency's interest or anyone else's interest.

How this is done procedurally can be done in many different ways, but I think it is important; quite apart from reaching a valid psychiatric judgment, you have to have the trust of the child. That includes a measure of confidentiality. A child can't possibly believe in you and confide in you, if the result is going to be that the psychiatrist isn't going to work with the child, but is going to work with the parents' recommendation that the child has no part in.

Q. Don't you feel that children are comforted and feel (58) loved and cared for by their parents?

A. We are talking about instances where the family structure has been disrupted. We are talking about instances—

Q. I am not talking about—

A. You are not talking about the normal family.

JUDGE GIBBONS: Can you give us some indication how much longer your cross-examination is going to be?

MR. ROTH: I think perhaps 15 minutes.

JUDGE GIBBONS: I think the court reporter would appreciate a recess at this time.

(Whereupon, a recess was taken.)

(All Counsel and parties being present, the following transpired in open court.)

JUDGE GIBBONS: Back on the record.

(Witness resumed.)

MR. ROTH: Your Honor, may I have the last question read, please, by the court reporter?

JUDGE GIBBONS: Mr. Reporter, would you read him the last question?

(Whereupon, the above requested portion of the record was read by the court reporter after which the following transpired in open court:)

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(59) *Continued Cross-Examination*

BY MR. ROTH:

Q. Doctor, do you feel that if you have an adversary process between—or if you have a proceeding whereby the juvenile can be given a hearing prior to the admission by the parent, don't you feel that the adversary relationship that is created between the parent and the child

will ultimately be disruptive to that family's structure in the event the child is ever returned to the family again?

A. I can't see how the fact of the hearing will make it any worse than it is, since obviously the disagreement exists before the hearing.

Q. What if a parent wants to put a child into a general hospital and the child is objecting there and the parent prior to putting his child into a general hospital has had the child evaluated by two or three neurologists and the child objects at that point; do you feel there should be a hearing?

A. I have very little experience with that kind of a situation, but it is my belief that that ought to be available. I don't think it would happen very frequently, but as I have said before, we all make errors and I think in an extreme situation that ought to be so.

Certainly I have known many instances where children have been forced to submit to something that was (60) unnecessary.

Q. Doctor, is it not one of the, let us say, legal requirements for parents to seek medical care for their children when they need it?

A. Yes.

Q. Do you not feel that parents who can't seek medical care unless they have to take part in a judicial proceeding, that they will not seek medical care?

MR. FERLEGER: Objection.

Unless you can define what he means by medical care. He has not testified to medical care—

JUDGE GIBBONS: He just did. He testified to a question about a neurological problem.

MR. FERLEGER: I want to make it clear that this case in the complaint or anywhere in the record that nowhere do we allege that neurologists need a prior hearing.

JUDGE GIBBONS: The question is the availability by a hearing device, would that tend to discourage parents from seeking medical or psychiatric assistance?

A. As a psychiatrist, it is my judgment and my experience that if a family can't work out situations such as a child going into a hospital, then there is some difficulty in that family. It may not necessarily be of any major proportion, but I would think it would occur very (61) rarely that a young child would go to court, but I think that possibility ought to exist.

I think that people do get unnecessary surgery; I think parents get involved with fads, with all kinds of quack treatments and there should be something available in an extreme situation that a child should have someone else to turn to.

JUDGE GIBBONS: You haven't answered the question.

Would the availability of this hearing device tend to discourage parents, if you will, parents in families where there are problems, from seeking assistance for their children?

A. I don't see why it would, because I think the issue of a hearing does not come at the point where you seek advice and help. It usually comes after you have gotten the advice and help. I don't see how it could.

Q. Then, Doctor, is it my understanding that anytime a parent wishes to obtain medical care, by the psy-

chiatric or non-psychiatric care for his child and there is an objection by the child, then, you would handle that by doing what plaintiffs' recommendation is, by having a hearing prior to admitting that juvenile or child into a hospital; is that correct?

You would have a hearing in every (62) circumstance?

A. At that juncture, I would try to persuade the child as to what is involved and what is necessary and why it is necessary. If it is not sufficient or if I am identified in the child's mind with the parents, I would see the child has a chance to talk with an expert who has not been involved in the proceedings up to that point and after that, I would think a hearing or legal representation in some way certainly would be helpful and would be helpful to the child psychologically in terms of his accepting the procedure to be performed and it certainly would make his cooperation more likely, which might be very necessary in some forms of treatment.

Q. Would you say that hearing would make the child more acceptable toward the ultimate treatment?

A. It may.

Q. Do you have any statistics to reveal that it would?

A. I do not. I have some experiences, but no statistics that would be meaningful in a large context.

Q. Do you feel there to be any stigma attached to having a juvenile undergo a hearing prior to admission, where he is now court ordered to a mental health facility?

A. No, I don't.

Q. Why not?

A. Unfortunately, there is a stigma being attached to (63) being in a hospital, which would be another reason

why all care ought to be taken before this type of drastic step be taken. I never heard the fact that a judge or attorney being involved in a proceeding increases that stigma.

Q. Doctor, do you realize what the nature of this lawsuit is doing, that it is going to have juveniles or children, we have not distinguished ages, that they will be treated the same as adults?

Do you feel that children are—you say zero to 18 should be treated the same as adults?

A. Yes, I do, in this regard that you are talking about. I certainly do.

Q. Do you feel that there are not developmental differences between a 19-year old and a 1-year old?

A. I certainly do.

Q. Do you feel that one who is an adult is generally more aware due to his experience and development to seek treatment if he needs it, than perhaps one who is age three or four?

A. Well, one has to be very careful about what age you are talking about.

Certainly in general, one's judgment increases over the years. By and large adolescents may have the kind of judgment that is required of adults, (64) although I think the issue of the way we develop judgment, it continues for many, many years. Someone who is four or five may have better judgment than one at twenty-one. It is arbitrary as to which you make the breaking point in terms of age.

If someone objects or thinks he has an objection, it is important to take that seriously. It is not necessarily true whether one is right or wrong.

Q. Have you discovered the percentage of cases in New York where juveniles are admitted incorrectly? Do you have any idea as to that?

JUDGE GIBBONS: Admitted now to a psychiatric residence facility?

MR. ROTH: In-patient.

A. I have no idea incorrectly, because presumably, if they were admitted incorrectly—there are two aspects of this, whether psychiatrically incorrect or whether when a hearing is requested, the Court rules that they ought to be discharged.

That happens quite frequently with adults. Our experience with adolescents has been this way:

The mental health review service has operated for several years and to the best of my knowledge, there has not been a hearing. That is important as to what you are asking, whether five-year olds will clog (65) up the courts and so forth.

I cannot recall an actual hearing taking place with an adolescent, someone that was not referred to us from the courts, I am talking about, because the attorney in discussing the rights and the issues with his client usually helps him to negotiate in some way with the psychiatrist to find some way for the treatment to continue.

Now, at times treatment does not continue with discharged cases where our advice has been that a child should remain in the hospital, but we didn't feel it was an emergency situation. We felt at this point it was better for the child to leave the hospital.

Very frequently they come back and they request clinic care and that treatment is usually much better than if one continues to keep a child in a hospital forcibly.

Q. Are you saying all your admissions are pursuant to court order that you have dealt with?

JUDGE GIBBONS: He did not say that.

A. No. What I was referring to was some 30 percent of our cases come from Family Courts where the Court has been involved rather than from social agencies or walking in by themselves.

Q. And the remainder of those does not involve any (66) court proceedings?

A. That's right.

JUDGE BRODERICK: Of that remainder, would you have any idea of what percentage of the admissions were based on an emergency situation?

THE WITNESS: Well, it is the majority. I would guess that 80 percent, maybe more.

JUDGE BRODERICK: Eighty percent are emergency situations?

THE WITNESS: Yes.

JUDGE BRODERICK: If the 80 percent are emergency situations, what part of the 20 percent would be as a result admitted pursuant to a court order?

THE WITNESS: I don't know of any instances where there was a court involved beforehand purely on the basis of the advice of the physician.

We do have that 80 percent that comes to the Family Court that comes from a court order, but that

other 20 percent, they are voluntarily admitted, where the doctor and patient works out that they should be in the hospital.

Q. Of that 80 percent that require emergency treatment, what do you mean by "emergency"?

A. That a child is judged to be immediately in danger of himself or to others.

(67) Q. Are there any provisions in New York law that permit somebody to be detained?

A. Yes.

Q. Why weren't they admitted pursuant to that section?

A. It is usually felt that that is a rather—first of all, some of them are.

Q. For those who are not.

A. Those who are not, we are incumbent to try to admit people and put people on the least stringent form of restraint, so that if someone comes to our emergency room or agrees with the doctor or says it is all right for them to be in a hospital, we will admit them on a voluntary basis.

There is even a provision in New York law that is even less formal than voluntary, informal basis where a patient is admitted where there are no legal records that the patient is admitted and I think the more we have of that, the better kind of psychiatric care we will be able to give the patient.

There are patients who need to be in the hospital under restraint. It is much better to get the patient to cooperate and all treatment is geared towards making the patient cooperate.

JUDGE GIBBONS: Is there any procedure in the hospitals that you have been affiliated with where (68) juveniles can voluntarily admit themselves without parental admission?

THE WITNESS: No, they can get out, but they can't get in.

Q. Are you aware of any situations in Pennsylvania where juveniles have been admitted inappropriately into state mental facilities?

MR. FERLEGER: Objection, he is not qualified on the situation in Pennsylvania.

JUDGE GIBBONS: The question now is, is he aware and he may answer that yes or no.

A. I don't know of any cases at all in Pennsylvania.

Q. Doctor, do you often testify in court cases?

A. No, I do not.

Q. Are you being compensated for your testimony today?

A. Yes, I am.

Q. How much are you being compensated?

A. Two hundred dollars—I am charging—that is my bill.

MR. ROTH: Your Honors, I have no further questions.

JUDGE GIBBONS: Any redirect?

MR. FERLEGER: Just one question.

Redirect Examination

BY MR. FERLEGER:

(69) Q. Just one question, Dr. Kandler.

With regard to the various percentages that have been discussed, you testified that in your facility, the number of children admitted, pursuant to, I believe you said, the voluntary provisions, admitted as an in-patient may be less than half of those at other facilities.

Could you explain why other facilities may be admitting many more juveniles than you would be?

A. Well, I can't talk specifically about juveniles, but we did a study with adults a few years ago, comparing our facility and I think it will answer your question, also.

I don't have the specific answer for children, but this included all admissions which included some children, but I don't know what the breakdown is and we compared our admissions with the Bellevue Hospital, because of some administrative—the situation—what happened was, that all the patients from Lincoln Hospital were all technically admitted to our hospital and their hospital. They were judged by Lincoln Hospital psychiatrists to need admission in a psychiatric facility and Bellevue and we would make individual decisions whether we agree with them or not.

After this initial screening, we only (70) admitted some 50 or 60 percent of those patients while in Bellevue over 90 percent were admitted.

Q. Why would that difference occur?

A. The difference in philosophy, the amount of help available and the amount that could be placed in the facility.

Q. So, you disagreed with the initial admission in a little more than half of the cases?

A. Yes.

Q. And in Bellevue they disagreed sometimes, and then sometimes they did not disagree?

A. That's right.

We had clinics available; we had day hospitals available; so that obviously sometimes, you hospitalize someone because that's the best alternative for the patient at the time although it is not a good one and at our facility where there were other alternatives possible, some did not have to be hospitalized.

There was no disagreement about the diagnosis or pain or trauma, but we had other means available.

MR. FERLEGER: No further questions.

MR. ROTH: Just one question.

Recross-Examination

BY MR. ROTH:

(71) Q. You said no other alternatives were available. My question is:

If a child is recommended for institutionalization, don't you think that normally occurs after all other treatment modalities are explored by the examining psychiatrist?

A. That is such a general question, I can't answer it.

In some places a psychiatrist will be careful about it and in other places he will not. I don't know how I can answer that numerically in a way that would be meaningful. He should.

MR. ROTH: Thank you.

JUDGE BRODERICK: Doctor, you indicated from your testimony that you were concerned about the possibility that a juvenile may end up in in-patient care that did not belong there. Let me ask you this:

Do you think that it would be sufficient protection if the child who objected were given the opportunity to get an individual psychiatric evaluation?

THE WITNESS: I am not sure I understand how to answer that.

That would be preferable for a step. So often, children find themselves dealing with people who do not represent them and as I said before, with psychiatric issues it is most important that trust and confidence (72) be established not only for treatment purposes, but for relation purposes and what happens beyond that is a legal question which is difficult for me to answer.

You are posing a question if what would then happen if the child disagreed with his own consultant.

JUDGE BRODERICK: Would you think a pre-admission hearing would be necessary if the individual psychiatrist had agreed with the other two evaluations or that as the attorney for the Commonwealth indicated was usual in these cases?

THE WITNESS: From a psychiatric point of view, I would be happy and satisfied if a child could have a psychiatrist of his own choosing or some one individual. For the legal requirement I am not sure

I can answer that question as to what would be sufficient.

JUDGE BRODERICK: I am not asking you to answer the legal qualifications. I am asking you whether you see any value to a legal value where the child who objected had the opportunity or an evaluation by a psychiatrist and who agreed with the others there should be in-patient care for that child?

THE WITNESS: I am trying to imagine the ramifications as to what would happen. Obviously, if there is a hearing, the hearing could be wrong, too.

Whether it is a psychiatrist or more (73) formal hearing situation, there could be an error.

I would have to say just as though there can be an appeal from a hearing, there ought to be some appeal at some place.

JUDGE BRODERICK: Even where you have the individual psychiatrist agreeing with the other two, you feel there is an advantage to having a full hearing?

THE WITNESS: There is just too much chance to error and I would agree, it is something that could affect the large segment of a person's life.

Even with a child, even a couple of months is a tremendous area of his life. It has ramifications because children grow so rapidly.

JUDGE BRODERICK: Have you in your experience in New York ever been confronted with a situation where the parents of a child wanted the

child to be admitted for in-patient treatment and you thought that in-patient treatment was not necessary?

THE WITNESS: That happens frequently, of course, where a parent must say, "I really think the child should be in the hospital." What happens usually, we work with the family as well as with the children and most of the time, some agreement is reached where the child should or should not be in or some other form of treatment should be instituted whether the child should (74) be in the day hospital or in the clinic, so that is the goal of treatment to get everyone working together and the precipitating event to that situation is something that has to do with the parents and with the child as well.

Most times parents say, "I want my child hospitalized," and we say, "It's not necessary."

JUDGE BRODERICK: Are you saying most of the time a parent wants in-patient treatment for a child—

THE WITNESS: I was thinking where a child is brought to the emergency room.

There is a big difference where a child is brought to the emergency room or to the clinic and parents do some preliminating sorting. If they bring the child to the emergency room, they have in mind that they wish somebody would take this child for a while. It is not an unknown idea in a parent's mind. Very often we disagree with that and try to find some other solution to the problem.

JUDGE BRODERICK: In such a situation where you don't disagree, is it your opinion that error has been made in your experience in admitting such a child to in-patient treatment?

THE WITNESS: Well, I thought about that question. It is difficult to answer because presumably (75) if I reach the decision, I don't know whether the error is being made. I presume it is not being made and unless for some reason someone else looks into the situation and disagrees with me at that instance, there is no real way of checking on that.

What I have seen is that many times within a day or two, a child is quite different and even though perhaps at that particular moment in the emergency room, it was necessary to place some restraints on that child and that is one of the problems.

I think psychiatrists make good diagnoses, but their prediction of behavior holds up for a short period of time and it has to be reviewed.

There is one instance that comes to mind of a child that was hospitalized and this was a personal patient of mine when I was in training in the hospital who had been in the hospital for several months and I wanted to discharge this child.

As a matter of fact, not even home, but to a residential treatment center and the mother wanted the child to stay in the hospital and refused to give the child clothes. I sent the police to the home to pick up the clothes.

JUDGE BRODERICK: In that situation you had no problem except for the lack of cooperation of getting (76) the child out of the hospital.

I have no further questions.

MR. FERLEGER: Thank you, Doctor.

(Witness leaves stand.)

(77) MR. FERLEGER: Plaintiffs call Michael Ingall to the stand, please.

MICHAEL INGALL, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Michael A. Ingall.

THE CLERK: Thank you, be seated.

Direct Examination

BY MR. FERLEGER:

Q. Doctor, what is your occupation?

A. I am a psychiatrist.

Q. Would you state for the record your current affiliations?

A. I am the medical director of the Providence Health Center in Providence, Rhode Island, which is a mental health out-patient unit.

I am also clinical professor of psychiatry at Brown University School of Medicine.

Q. Would you please state your background as briefly as you can in psychiatry especially with reference to children and legal matters?

A. I am a graduate of the Chicago Medical School. I did three years of residency at Boston University Medical Center, one year of which was a Fellowship in child psychiatry which was spent at various psychiatric (78) facilities in Boston, one of which was the Roxbury District Court Clinic, where I served as a consultant to the Court, seeking alternatives to in-patient institutionalization or jail for people who were before the Court on drug related offenses.

Most of them were adolescents and we sought community based out-patient treatment or residential treatment in a half-way house for them.

Q. Doctor, have you been the recipient of any awards or honors in your field?

A. I received from the American Psychiatric Association a Faulk Fellowship, which is an honor.

I am a member of Alpha Omega Alpha, which is an honorary medical fraternity.

Q. Are you certified by the American Board of Psychiatry and Neurology?

A. Yes, in psychiatry.

Q. Where are you licensed to practice medicine?

A. Rhode Island and Massachusetts.

Q. Doctor, with reference to your Curriculum Vitae which I will show you and this is marked plaintiffs' Exhibit 6—

MR. FERLEGER: I apologize. I have to call him out of order because of his airplane schedule.

Q. —is this a summary of your qualifications and (79) background?

A. Yes, it is.

MR. FERLEGER: Do you have any questions on qualifications?

MR. ROTH: No, I don't.

MR. FERLEGER: May I proceed, your Honor?

JUDGE GIBBONS: Yes.

MR. FERLEGER: Thank you.

Continued Direct Examination

BY MR. FERLEGER:

Q. Dr. Ingall, I wonder if you could discuss just briefly the general question of the sources from which children's emotional difficulties arise and what the relationship is between that and the family structure that Mr. Roth has been talking about?

A. In my opinion, most of the children whom I see, most of the young children and adolescents whom I see, what emotional problems they have usually is a function of intrafamilial problems, that the problems of the children are manifestations of problems that go on within the family.

There are occasional psychiatric problems that tend to be psychoneurological in character which are perhaps not stemming from intrafamilial conflict, but which in and of themselves often give rise to intrafamilial conflict because of disagreement of the management (80) of the child and home.

Q. Is it your opinion, then, that it is the family that has problems or is it usually the presenting child that has the problems?

A. Well, I would say with most of the kids and adolescents that we see at our clinic, most of them are brought by parents or come with parents. Usually, they come at the suggestion of a school or court, the presenting complaint being not that of the child, but of the parents, saying, "My child is doing such and such. I would like you please to fix him."

Q. In those situations, can you explain why the child, rather than another member of the family would be the one who would be identified in the role of the patient?

A. I think it is because children are little and are in a subordinate position with regard to their parents.

If a parent decides the kid is going to go to a psychiatrist or is going to go to a hospital, the child's objection does not carry the weight that an adult of equal stature would carry. It is much easier to hospitalize a child if you are an adult than it is your brother.

Q. In those situations, Doctor, with what frequency have you found that parents suffer from some emotional illness as well as the children they seek to be put into (81) treatment?

A. Frequently and—

Q. You may explain.

A. As I said before, if we have a child or adolescent who is presenting in this way, one of the early goals in treatment we have is to see the family, either to go as a family unit if things are not too chaotic or at least to see the parents separately from the child, in order to get the focus of the kid as a scapegoat as to what we see as intrafamilial problems to try and get the family working together.

Even if the family says, "You have a problem; how can we help," that is better than saying "You have a problem; go get it fixed."

Q. Do I understand that you said that the child is at times the "scapegoat" of the family's problems?

A. Yes, it's a strong word. I don't use it myself.

Q. Doctor, I wonder if you could give us your opinion with regard to whether or not in a non-emergency situation, there ought to be a judicial hearing prior to the commitment of a child to an in-patient mental institution?

A. I think there should be. I think particularly so in the case of a child. An adult or an older adolescent has the capacity and the maturity to make his own case, either to the admitting psychiatrist at a state hospital (82) or to an examining psychiatrist at another facility and he can convince, perhaps, that psychiatrist that he should not be hospitalized. He can say, "Look, they want to put me in the hospital because my mother wants to go out every night." He can say, "Father wants to put me in the hospital because he is jealous of me."

He can make a convincing case for himself. A younger child often does not have that capacity and he may not be able to say, "Look, okay, I need treatment, let me go on an out-patient basis." He may not know what resources are available to him as an alternative.

Q. What function do you think the hearing could have in that kind of situation?

A. I think in that situation the child would have an advocate who was clearly representing him who would explore with experts, if necessary, alternatives to hospitalization and would review the need for hospitalization, which is for me a last resort.

Q. Can you give us your opinion on whether or not you feel there would be any trauma or any adverse psychological effect on a child of having such a hearing in the child's behalf?

A. I think there would not. I think if the situation is such that a hearing must be arrived at, that the parents and child are in such conflict, that this must (83) ensue, that there already is severe parent-child conflict and disruption between the family and that such a hearing can certainly do no further harm.

I don't think it is harmful to a kid to hear what a psychiatrist or anyone else has to say about him and I don't think it is harmful to hear diagnostic terms bandied about.

Q. In that situation that you are describing where there is family conflict or at least, disagreement, do you feel that the parents are in a position to judge the best interests of their child and what kinds of treatment the child ought to obtain?

A. Well, even when there is family conflict, often, it is the case that parents do want what is best for the child. I think it is an unusual circumstance when parents are really adversaries of the child.

Even however when parents want what is best for their child, sometimes their judgment because of their intimate involvement with the situation and very emotional strong feelings that they have about their kids which is natural, often then, their judgment is not the most objective.

Q. Are there occasions—

MR. FERLEGER: Strike that.

Q. In the context of a family that is seeking (84) institutionalization for a child, have you had any experience with misinterpretations of a child's behavior by members of the family or by psychiatrists that the family has sought out?

A. I got hung up on the word "institutionalization" and that means something different than the word "hospital".

Can I elaborate on that?

Q. Yes.

A. For me, institutionalization has a negative connotation. There are many institutions, a college is an institution, this Court is an institution, a psychiatric hospital is an institution. When we talk about the negative effects of institutionalization and we usually talk about the negative effects rather than the positive effects of institutionalization, we are talking about a situation which is usually a detrimental one, so I am opposed to institutionalization, voluntary or involuntary, and I am very much for hospitalization when adequate treatment is available and I realize it is not a right-to-treatment suit, but I think there is a difference.

Q. When a child is to be placed possibly in an inpatient facility which may be detrimental or may be positive, in your terms, are there problems with the psychiatrist, that they are relying on simply the parents for the factual information upon which their decision is (85) based?

A. Sure, everything that you hear from a patient or his family is given with a bias. We all try to present ourselves in the best light we can.

Q. Do you feel that you, as a psychiatrist or a judicial officer at some sort of hearing should be the person to resolve those factual conflicts?

A. Well, if you are talking about strict questions of fact, you know, did the child do this at such and such a date—

Q. Yes.

A. —Well, I think that the legal profession is much more adept at dealing with objective fact than the psychiatric profession, although sometimes I think objective fact is not as relevant as subjective emotions.

Q. Now, have you had any experience in working with Courts in terms of giving your advice on the medical end after the Court has determined the legal questions?

A. After the Court has determined the legal questions?

Q. With regard to a need for treatment.

Have you had any experience in providing input into what happens therapeutically to the subject?

A. My experience at the Roxbury District Court, my consultation with the patient or client occurred after an indictment, but before sentencing, so I would confer (86) with the judge prior to his sentencing of the client or defendant and then, the judge would decide whether or not to make treatment in the community an alternative to incarceration.

Q. Will you explain, Dr. Ingall, the reasons that you think as a psychiatrist, that it is important for there to be a hearing with an advocate representing the child's interests?

A. Well, if I have to treat someone who is involuntarily committed to me, that is possible. If I, however, am the one who, in the eyes of my patient, is incarcerating him within a hospital, then, I become (a) therapist, and (b) also jailer, and that is a confusing role for me and the

patient and it makes treating the patient difficult because it heightens the ambivalence to me.

I have treated patients who were submitted to me and the Court would say, "You have to go see the shrink or you go to jail," and the kid would come in and see me and I'd say, "Why are you here?" and he would say, "The judge said I have to be here."

I would say, "That's a sad situation and we have to meet together, so let's make the best of it," and we would form a therapeutic alliance in that way.

Q. And you feel it is difficult to form such an alliance if the psychiatrist is the one who certifies (87) the need of hospitalization for the patient as in the state's regulations?

A. Unquestionably.

Q. Dr. Ingall, in the non-emergency situation where necessity for hearing might involve some delay of a week or two, perhaps, can you see any reasons, number one, that the delay should be so terrible that we shouldn't allow such a delay or, two, do you see any advantages to such a delay?

A. If it is a question of an emergency commitment where imminently a child is in danger of hurting himself or others. There should be provisions as there are in this and in most states for involuntary hospitalizations.

Q. In a non-emergency situation?

A. In a non-emergency situation I don't see any harm and I think there are advantages to a delay.

Children, as we all know, have a tremendous capacity to recover, to improve and to change.

You know, all of us know and perhaps remember ourselves when we were adolescents, one day you are

in love with a girl and you know, she is the end of the world and she won't have you and you are going to die. You are going to go out and kill yourself and the next day you meet somebody else and you are on top of the world.

Children are very fluid. Also medically, (88) a child admitted to a hospital or a child on an out-patient basis who is medically ill, may look as though they are on death's door and indeed be on death's door one day and the following day become completely well, running around.

Saturday, my daughter was home in bed, vomiting, pale, feeling awful, and Sunday morning she was running around outside.

Q. Do you think in terms of the psychiatrically ill juvenile, that the delay might help things? Is that what your testimony is?

A. Yes, I think hospitalization is a very serious step to take with an adolescent, child or an adult and if there is a waiting period in a non-emergency situation that things can change so by the time the hearing comes around, there is no need for the hearing. All are agreed that hospitalization is or perhaps things—or perhaps hospitalization is not needed or perhaps the situation deteriorates where people decide, the child included, he needs to be in the hospital.

Q. Can you please explain why you would wish to make a distinction between parents taking their children for treatment in an in-patient psychiatric institution as opposed to treatment by a neurologist or by a physician for a physical problem along some other basis?

(89) Why is a mental hospital such a different place?

A. A mental hospital is a different place, because there's stigma attached to it and because depending on the hospital, it can be a dangerous place.

There can be situations in which a child is exposed to other patients who are dangerous to him and if there is not sufficient staffing within the hospital to insure the safety of all, it can be a dangerous place.

Q. Is there any other way in which an institution can be dangerous?

A. There was an article in the Sunday Times yesterday about kids who were in a facility, who were being raped and extorted and they shouldn't have been there.

Q. Now, Doctor, with reference to the state's regulations which were adopted subsequent to the institution of this lawsuit and which provides for the possibility of a hearing for those 13 through 18 year olds after commitment, can you give us your opinion on whether or not such a proposed commitment hearing can be harmful to the psychological well-being of the child?

A. Whether the hearing can be harmful?

Q. Whether having the hearing after somebody is already in the institution might be detrimental.

(90) A. It is far more preferable to have the hearing before-hand.

Q. Why?

A. Because you may avoid the necessity of hospitalization in the first place.

Q. With regard to children who are, let's say, under the age of 10 or 11 or 12, who I think we can all agree might not be able to identify their need for an attorney or for a hearing, do you think there would be any benefits to a prior hearing with regard to those children?

A. Yes, I think if a child has a serious objection to hospitalization which cannot be overcome by talking with his parents and with a doctor on the outside, that that child is entitled to legal representation at a hearing, providing it is not an emergency situation, prior to the decision to hospitalize him.

Q. Do you feel that such a hearing or provision of Counsel would interfere with the treatment of juveniles by psychiatrists?

A. A hearing beforehand?

Q. Yes.

A. You mean if the child is later admitted to a hospital?

Q. That's right.

A. Would it interfere?

(91) Q. Yes.

A. No, I can't see that it would.

Q. Do you feel that such a hearing would be a substantial hindrance to the relationship between the parents and the child?

A. No, I do not.

MR. FERLEGER: Mr. Roth, your witness.

MR. ROTH: Thank you.

Cross-Examination

BY MR. ROTH:

Q. From your testimony, I understand that you are opposed to hospitalization until every other avenue has been explored; is that correct?

A. Generally, yes.

Q. Do you feel—let me ask you, are you familiar with our procedures? Were you in court today when Dr.

Kandler referred to "Annex 'a' ", about the additional safeguards?

A. Yes.

Q. Are you aware of the two-step procedures used in Pennsylvania?

A. For what?

Q. For the possible institutionalization of a child.

A. You mean under Annex "a"?

Q. Yes.

(92) A. My understanding is that a child must be taken to an outside facility, outside the hospital, certified there and certified at the hospital to be admitted and then on an uncertain date after admission, has a right to a hearing.

Q. Well, that part is true, but basically, I am just familiarizing you with it because I'd like to ask you a question about it.

The child is taken to a recognized agency or a private psychiatrist and a psychiatrist makes a recommendation, for, if you will, institutionalization and consequently, the recommendation, along with the parent and child, arrives at the institution and an individual examination is conducted and if that examination corroborates, agrees with the first, then, the child is institutionalized or recommendation is made for the parent and the parent may or may not institutionalize the child and once the child, age 13 or older, objects, the child is provided with Counsel and a hearing.

Now, you have stated and I don't think the Commonwealth is at all at odds with the statement, that hospitalization is a last resort.

Would it not be your professional opinion that based on this procedure, that the psychiatrist generally would

seek some form of treatment, other than (93) institutionalization?

A. Not necessarily.

Psychiatrists vary in their opinions as to the need for hospitalization. There are some psychiatrists who like to hospitalize most of their patients initially for a diagnostic workup.

I disagree with that. There is also a situation where a poorly funded, poorly staffed clinic in the community may be overwhelmed with the number of cases asked to treat. And it is a fact they have too many cases and the clinic may say to the parent who comes in, "Sure, as long as you don't bring them in," and they will acquiesce.

Q. Let's assume you have a clinic overworked and that is so because there are no other modalities of treatment for the child, so they recommend institutionalization and the director of that institutional place has an individual examination conducted, do you think the results of that examination will be the same as the first?

A. In the situation you outline where there is no alternative except institutionalize, I think that carrying with it the bad connotations that it carries is probably worse than leaving the child in the community.

Q. I inform you this is a case as to the challenge of the type of treatment.

(94) Bearing that in mind, the question remains, if no other form of treatment is available, whether it is in a county in Pennsylvania or in Wisconsin or where-have-you and the only way to provide treatment for that child would be institutionalization, would you be opposed to it?

A. Yes, I would, on the basis that two psychiatrists feel the child is mentally ill and that other resources being

unavailable, hospitalization must be resorted to and the child objects, then I think that child has a right to object and a right to a hearing and a right to Counsel to state that objection.

Q. Let's follow that out.

Assuming all those facts were as we have discussed, where there be no other form of treatment in that particular area and that the child were afforded a hearing and it was determined that the child does need a method of treatment which is unavailable and that form of treatment could be met at an institution, would you object to a judge finding or holding that a person should be institutionalized for that type of treatment?

A. If psychiatrists feel that only in a state institution is the form of treatment that is available that the child needs and the child objects and the case comes to a hearing, then I would hope that at that hearing it would be decided that despite the objections of the child, (95) he would have to go to that institution.

I am not opposed to involuntary hospitalization. I think there have to be safeguards against it, however.

Q. You don't feel those safeguards are available by permitting a hearing after the child has been committed?

A. That is one level of safeguard. I believe it would be better to have the hearing beforehand.

Q. You prefer a hearing beforehand but you are not objecting to one after?

A. I think anyone who is hospitalized involuntarily is entitled to hearings at various stages, be it a child or an adult.

Q. Now, you have indicated that parents who necessarily come to your facility are not in the best ways to assess the problems of their children; is that correct?

A. Some.

Q. Some?

A. Some parents.

Q. Don't you think the mere aspect of the fact that a parent brought his or her child to you presumes that the parent is acting in the best interest of seeking treatment for the child?

A. That is not always the case.

I have had a very significant number of (96) patients who have come to my clinic which is a sizeable one, where the purpose of bringing the child to treatment has been to accuse him, to punish him, to separate him from the home. The motivation is not always good. Usually it is, but not always.

Q. And, in those situations, how do you react; what do you recommend?

A. I recommend alternatives to hospitalization. I will recommend either seeing the family together on an out-patient basis as a family unit. I will recommend seeing the kid on an individual basis and seeing the parents separately, if they will agree.

Q. So, in other words, Doctor, wouldn't it be very difficult, again, referring to our regulations, that if someone came to you and you did not recommend institutionalization, it is going to be very difficult for that parent in order to put that child into the institution, wouldn't that in effect occur in Pennsylvania?

A. Could you repeat that?

Q. If we are using the two-step process and the parent comes to you and you feel the motivation of the par-

ent is not correct, and you do not recommend institutionalization, the parent won't be able to have the child admitted?

A. There are plenty of psychiatrists around, the parent can seek alternate opinions.

(97) Q. The parent would begin to doctor-shop, is that what you are saying?

A. Possibly. We had had within the past week a mother bring a kid to the clinic who had originally been to child welfare services, wanting her child placed, because of his behavior, in a sort of state institution for abandoned children; I am not sure what the equivalent would be here, but it is not a psychiatric institution.

If a family goes in the hospital and the child is left without care, a foster—a state institutional home for kids. The family was evaluated by that service and the kid was felt to be not in need of shelter services. In that case, the mother came to our clinic, simply saying she would like her kid put in a psychiatric hospital because she is tired and she can't take care of him. We got her some help.

We did not hospitalize the kid, not to punish him, just because she could not take care of him and she was labeling the kid as emotionally disturbed to get him out of the home.

It was for his benefit, really, she couldn't take care of him, but we did give her support with a homemaker and visiting nurse coming in and rallying her family around her.

So the kid did not have to be put in a (98) state institution.

Q. The best interest of the child in that situation was served, was it not?

A. Yes, without institutionalization, even though that is what was originally requested and we were able to resolve it.

Q. And the parent sought help from your clinic?

A. Yes, and we didn't need the hearing.

Q. What would happen in your opinion, Doctor, if a hearing were provided and the juvenile had an attorney and the attorney looks at all the facts and he decided to capitulate and decides that it really would not be in the best interest of his client to have a hearing; that he is convinced?

A. It would be in the best interest of his—

Q. "I have reviewed all the facts and evaluations of the psychiatrist who my client has had"—is not too certain whether he should go to a hearing. What would you do in that situation?

MR. FERLEGER: That is not within his competence if an attorney decides to waive a hearing, if the Court grants attorneys to waive such a hearing.

JUDGE GIBBONS: Sustained.

Q. Would you define what you know to be an emergency situation as versus a non-emergency situation?

(99) A. An emergency situation is one where a patient is imminently dangerous to himself or others as a result of mental illness, whatever that is.

Q. And a non-emergency situation?

A. Is one in which that is not the case; in which those criteria are not fulfilled.

Q. Could the modality of treatment still be essential for a non-emergency patient as immediate as for one who is, say, dangerous to himself or others?

A. You will have to say it again. I'm sorry.

Q. For example, could a person who is a non-emergency commitment require help as quickly as one who is a candidate for an emergency situation?

A. As I undestand your question, you are asking, is a non-emergency situation equally an emergency as an emergency situation?

Q. In essence, yes, in terms of treatment or hospitalization.

A. The answer is no.

Q. Let me ask you this:

Can a patient—can a prospective applicant, because he has to go through a judicial process, be delayed to such a length of time that what was a non-emergency situation becomes an emergency situation, where no one becomes fully aware of it?

(100) A. Patients die with their rights on and with their rights off. Patients die who are in treatment and patients die who are out of treatment.

We psychiatrists as a class, are pretty good at formulating diagnoses. We are pretty good about dealing with people about how they feel; we are pretty good in listening to them. We are bad in predicting what they are going to do. People suicide and kill others who are in psychiatric treatment. That is despite efforts of psychiatric treatment.

To lock people in psychiatric hospitals on the vague prediction they may do harm to themselves in some uncertain way or some uncertain time is a severe abridgement of their civil rights.

Q. Is it your opinion that a hearing should be provided only for the juvenile who objects, or for any person, you know, 18 years of age and younger?

A. Only to the juvenile who objects.

Q. So, in other words, if you have a juvenile who cannot even formulate an idea, who is so removed, if you will, then you feel it would be in his best interests to allow the parent to admit him, notwithstanding the fact that he has not objected?

A. If the child is unable to object?

Q. He is unable to object.

(101) I am sure you have seen—well, I'm sorry.

He is unable to object.

A. Well, at what age?

Q. Let us say, it is irrespective of the age. As long as he is in the age group.

A. Are you implying the child is unable to object because of some emotional or mental impairment?

Q. As you may know, the statute addresses itself to not only mentally disabled, but mentally retarded.

A. Yes.

Q. So if you have a severe mentally retarded person—

A. If you have someone who is that severely mentally affected that he can't speak for himself when asked if he wants an attorney or what his rights are, if he can't respond to that at all, I think chances are, he requires inpatient treatment, if someone else thinks he does on the outside.

Q. What about a person that is so out of touch with reality, that one of their behavior modes is objecting to everything? That their objection is really not an objection as you or I would know it, but it is just a form of their behavior pattern; do you feel that a hearing should be provided in that instance?

A. I can't picture the kind of person that you are talking about. Someone who objects; when you say yes, (102) he says no?

Q. Yes.

A. Someone who is just obstinate?

Q. Correct.

A. Well, I don't think that is a ground to commit someone to a hospital.

Q. I am not saying that is the grounds.

I am saying that is one of the elements of his behavior and assuming other conditions of his behavior warrant admission into a hospital, do you feel in that situation the person ought to be afforded a hearing?

A. Yes.

Q. Why?

A. Because he is a human being who has rights and if he objects to being hospitalized and he is not in danger of harming himself and others imminently, that he has a right not to be locked up in a hospital.

Q. So, it is your feeling and opinion that a hearing should be provided to anyone prior to their admission into a facility where they object to that admission; is that correct? Notwithstanding the fact that to object may be valid or invalid.

A. That anyone who does not want to be hospitalized on a non-emergency situation, we are talking about?

(103) Q. Yes.

A. That if someone does not want to be hospitalized, sure, I think he should have a hearing.

JUDGE GIBBONS: Regardless of age?

THE WITNESS: Regardless of age.

Q. Are hearings provided in Rhode Island?

A. Under the current mental health law, after hospitalization, but not before.

JUDGE GIBBONS: Does Rhode Island have any provision for juveniles voluntarily admitting themselves without parental involvement?

THE WITNESS: I don't know.

In our clinic we will see juveniles without parental consent and most of the time we will try to get parental involvement, if only for consent later.

Q. Does your clinic provide in-patient treatment?

A. No, we do not.

Q. Have you ever been associated with a state institution?

A. I have not directly worked for a state institution, but I am currently associated with the state institutions in that I teach there and have rather extensive liaison with them, because that hospital has a large course of referrals to my clinic, which is a public clinic. So I am quite familiar with the situation in an in-patient (104) state hospital facility.

Q. There's been some discussion with the prior witness about juveniles calling for help; do you think there's anything to the fact that a juvenile is often objecting because he is seeking help?

A. I don't think a juvenile objecting to hospitalization is a plea to help. It is possible you might interpret that behavior that brought the child to a hospital, psychiatrist or a hearing, like stealing or using dope; you might interpret that, if you wish, as a plea for help, but refusal, I don't see as a plea for help, no.

Q. So, that it is true that the key to diagnosis would be not the subjective symptoms which the patient reports, but the acting-up behavior?

A. That can be viewed as a symptom.

Q. Aren't juveniles reluctant to provide that behavior?

A. They do that with a great deal of zeal, from my experience and they are less happy to report they are depressed.

MR. ROTH: If it pleases the Court I would like Mr. Moss who is associated with me to continue with some questions.

JUDGE GIBBONS: All right, proceed, Mr. Moss.

Continued Cross-Examination

BY MR. MOSS:

(105) Q. Dr. Ingall, you stated in your direct examination by Mr. Ferleger that you were opposed to hospitalization and institutionalization because you feel other alternatives are not explored and you feel for that reason the child should have a prior hearing, because he cannot convince the medical people treating him that he should be treated in some other alternative.

Do you have any evidence that indicates that other avenues or other alternatives are not explored by the medical people treating the child?

A. I know of circumstances in which people have been referred for hospitalization by virtue of the fact that the doctor whom they saw was too busy to make a complete evaluation of the situation and felt that it would be

easier to admit the child to an in-patient facility, where other staff, besides himself would be able to do this.

Q. You know that through a personal experience?

A. Yes, I do.

Q. Do you feel that having a prior hearing is the only route to making these other alternatives?

A. I think more community alternatives need to be made available. I don't think the hearing is the end all. No.

Q. Cannot this function and isn't this function done by the other social agencies involved with the child and isn't it true that other alternatives are explored?

(106) A. Explored?

Q. Yes.

A. Often that is the case.

Q. You stated that—

A. I think we are talking here about the exception, rather than the rule. I don't see every kid for whom hospitalization is proposed as coming before a hearing.

Q. You stated that there is no trauma from a prior hearing because there is already a disruption in the family patterns.

Is that an assumption on your part and do you have any figures which would show the percentage of children admitted from homes where the family has been disrupted?

A. You mean do I have proof that a hearing is not—

Q. Have you read any studies or have you done any studies of your own which would indicate that in most situations, the family has been—the family patterns have been disrupted?

A. Yes, I have read studies—they have been disrupted by hospitalization or beforehand.

Q. You stated that there is no trauma which develops from a prior hearing, because the family patterns have already been disrupted, right, which is an assumption, if I understand your response, is an assumption on your (107) part, then, that in all situations in which an adolescent is in need of hospitalization or reaches the point that he is in need of acute psychiatric care, that the family pattern has been disrupted; that there is a break in the family pattern.

Do you have any knowledge as to any studies having been done or any figures which support this?

A. Figures—I am sorry, you mean that kids who are in hospitals come from families where there is emotional disturbance among the family?

Q. That the family pattern has been disrupted, to use your term.

A. Has been disruptive?

MR. FERLEGER: Disrupted.

A. I know from personal experience and textbooks and articles that I have read, there is a good deal of evidence to show that kids who are in psychiatric hospitals come from families where there has been familial disruption.

Q. You don't know whether there's been disruption which has taken place prior to hospitalization?

A. Yes, prior to hospitalization.

Q. Prior to the hospitalization?

A. Yes.

Q. You stated that sometimes, by the time the hearing would come around, it would not be needed.

(108) What percentages of these cases have you seen?

A. We don't have a hearing system where I work prior to hospitalizations, so I can't tell you what percentage.

Q. What about the proposed hospitalization hearing situation? You testified to something in regards to the hearing not being needed.

Do you recall what you stated?

A. Yes, I think I said that if there is a delay between the time hospitalization is proposed and a hearing takes place, that it may be if that interim between the proposal and the hearing when a decision will be made, that the hearing—that family communication is enhanced to the point that they can resolve that hospitalization is not needed and that alternative treatment can be used or alternatively the situation may deteriorate where all involved feel that hospitalization—either the child agrees that hospitalization is needed or else the situation reaches emergency proportions, in which case emergency commitment can be applied.

Q. In a situation where the hearing is not needed and actually what has taken place is that the wounds of the illness have healed themselves through time.

A. I wouldn't go to that extent. I think if you have reached that kind of situation, things are not going to be (109) better forever after, simply because hospitalization is going to be avoided.

Alternative treatment is often very useful.

Q. You were asked on direct examination, that if a proposed commitment hearing were held, would it be harmful to the child and you stated, you feel that it is better to have a hearing before.

I would like to ask you that question again and respecting your desires of wanting the hearing prior to commitment, can you tell me whether you feel in your professional opinion whether a proposed commitment hearing would have any harmful effects?

A. No, I can't see that it would.

Q. You did state it would not hinder the treatment process if the child is represented by Counsel prior to the commitment; that it would not hinder the relationship between parent and child.

Can you tell me why?

A. I can't see any way in which it would hinder it. You are implying that it would.

Q. I am just asking you for your opinion and you stated on direct—

A. I don't think it would be harmful.

Q. You have no reasons why?

A. Yes, it would not be harmful.

(110) Q. As a psychiatrist—

A. It is not harmful for a child to meet with an attorney or guidance counsellor working on his behalf. It can be beneficial.

Why should it be harmful to meet with a lawyer? They are not so bad people.

Q. You are a therapist and in private practice and treating a child and it reaches the stage where you feel the child needs to be hospitalized and the child does not accept your suggestion, you then take the next steps to have him hospitalized and the jurisdiction that you happen to be in there is a statute that says that there must be a prior hearing.

The only person who has worked with the child and who is aware of the child's illness is you, the therapist, and you are the only person who can testify to the Court what is wrong with the child and why he has to be institutionalized.

The child is in the courtroom and you are there testifying. Are you not becoming an adversary to the child?

A. In a sense, yes, you are right.

In a sense, that might be disruptive to our treatment relationship. However, more disruptive would it be if I didn't have a lawyer representing that (111) child and I, myself, by picking up a pen, signed a paper and said, "Too bad, you are going whether you want to or not," and it was all on me.

That would be much more disruptive.

MR. MOSS: I have no further question.

MR. ROTH: No further question.

MR. FERLEGER: No further question, your Honor.

JUDGE GIBBONS: Thank you, Doctor.

We will recess until two o'clock.

(Whereupon, at 1:00 o'clock p.m., a recess was taken.)

Afternoon Session

(Whereupon, at 2:00 o'clock, p.m. all Counsel and parties being present, the following transpired in open Court.)

MR. FERLEGER: Your Honors, at the end of Dr. Ingall's testimony, I neglected to move for the admission of his Curriculum Vitae.

JUDGE GIBBONS: It is admitted.

JUDGE HUYETT: Which Exhibit is that?

MR. FERLEGER: Number 6.

(Whereupon, the Curriculum Vitae of Dr. Michael A. Ingall was marked plaintiffs' Exhibit 6 in evidence as of this date.)

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(112) ELI CHARLES MESSINGER, Sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Eli Charles Messinger.

Direct Examination

BY MR. FERLEGER:

Q. Doctor, what is your occupation?

A. I am a psychiatrist, a child and general psychiatrist.

Q. What is your present affiliation or appointment?

A. I am assistant attending at St. Luke's Hospital Center, New York City.

I am a clinical instructor in psychiatry at Columbia Medical School College of Physicians and Surgeons and I am currently employed at the Neighborhood Health Service program.

This is a federally funded comprehensive health care program in Manhattan. It has a mental health unit of which I am acting psychiatric director.

I also have a small private practice and work with both children and adults.

Q. What has been just generally your experience in terms of years and type of treatment in child psychiatry?

A. I am a trained child psychiatrist. I had two years of child psychiatry fellowship at Bronx Municipal Hospital Center in the early 1960's.

(113) The two years were separated by two years in the Public Health Service in which I served as psychiatrist and chief medical officer at a federal reformatory in Oklahoma.

There, I worked with youthful offenders.

I have been in the practice of child psychiatry since 1965 and all my salaried positions have been in this area.

Q. Dr. Messinger, are you certified by the American Board of Psychiatry and Neurology?

A. Yes.

Q. When did that certification occur?

A. In 1966.

Q. And are you also certified in child psychiatry?

A. Yes, in 1970.

MR. FERLEGER: Any question, Mr. Roth, as to qualifications?

MR. ROTH: No question.

Continued Direct Examination

BY MR. FERLEGER:

Q. Dr. Messinger, one brief thing with regard to your qualifications, have you given any talks or written

any papers with regard to the relationship between law or legal rights and psychiatry?

A. Yes, I have.

I have delivered a talk to the American (114) Orthopsychiatric Association on some interconnections between the legal and psychiatric systems.

I have written an article for the Journal of Medical Probation on the psychiatric treatment of the youthful offender.

Q. Doctor, can you describe to the Court what age children you have treated and what institutional or non-institutional contacts you have had?

A. My experience with in-patient psychiatric work with adolescents and younger children was confined to the years 1960 through '65, with the two years in the Public Health Service and there, I worked with children of all ages, down to at times, three or four, who had to be hospitalized and with adolescents who were in the hospital, too.

Since that time, I have treated children and adolescents of all ages, but not in an in-patient setting.

Q. Does your facility which you are presently psychiatric director for, ever refer children to in-patient settings?

A. Yes, but very rarely.

Q. Dr. Messinger, can you please describe the current orientation in child psychiatry regarding the role of the family and the family structure and the difficulties (115) that children may have?

A. Yes, I believe that there is wide-spread agreement in the field of psychiatry, as well as the other mental health professions, social work and psychology, that the

problems of children and the problems of their parents are inextricably connected; that the family should be viewed in many instances as the locus of pathology or trouble; that it is impossible to understand the symptoms and behavior of any one member of the family without understanding its role in the family in maintaining the family equilibrium; that symptoms are often an expression, be it a distorted expression—a distorted attempt to communicate, make demands on, ask help from, seek the support of other members of the family.

I think that it is unwise to think in terms of blame of either the parents or the children, but that it is wise and necessary to view the interrelations between the problems of the designated parent—designated patient, excuse me. Certainly, if that patient is a child or adolescent, to see those problems in terms of the whole family structure.

Q. Does it occur, Dr. Messinger, in families which present a child for psychiatric treatment that the families or parents, for example, in families might also be in need of psychiatric care?

(116) A. Very often, that is the case and this is not a current fad in psychiatric thinking.

It really goes back a full half century to the beginnings of the child guidance movement which had its origins in psychiatry primarily and here in Philadelphia, and this was recognized in the very structure of the child guidance clinics which were organized so that the psychiatrist—usually a psychiatrist who worked with a disturbed child. had as an ally in therapy the social worker who did counseling or case work with the parents.

Q. Dr. Messinger, in terms of this family orientation of psychiatry, do you have any opinion as to whether

or not an institution, such as a state mental hospital or a similar facility would be more or less likely to involve the family than a community facility?

A. In my experience, it is inevitable, that an institutional setting pays less attention to family pathology and family dynamics, than does a community facility.

Q. Why would that be?

A. I think that there are a number of reasons, starting from the most obvious. Many of them are physically separate from where the family resides and perhaps, at best, the family can afford to take a bus trip or a train trip to a facility in the countryside maybe once a week (117) or once a month.

Sometimes, the treating psychiatrist or social worker isn't there on the day that the parent who is taking time off from work, for example, or coming on a weekend. The treating psychiatrist, he isn't there to have an interview with that person, but there are other considerations which are less tangible and that has to do with orientation and I think the orientation of institutions tends to be that the designated patient is the sick one, that the pathology resides within that individual and they tend to overlook, or at least under-emphasize the ways that those problems—under-emphasize the interplay between the designated patient's difficulties and those of the rest of the family.

I might add that this family orientation to psychological difficulties has been one of the major trends in the last 10 or 20 years.

Again, Philadelphia happens to be a center of research and treatment in this area and the modality of treatment which has emerged from this orientation is called conjoint family therapy. That is, all members of the family

are involved, usually with the same therapist and in the same room at the same time in working out their problems

Q. Is that because the family is seen as needing help (118) as a whole or is the family just there to help with the child's problems?

A. Both. I mean, even if you have a disturbed youngster who has a disturbance onto himself, so to speak, the family does need assistance in its coping with that. Almost inevitably.

Q. Dr. Messinger, in the light of this situation, do you feel that parents are always in a position to judge what is best for their children in terms of psychiatric care?

A. I think that when a parent or when parents knock on the door of a social agency or a psychiatric facility and say in effect, "Do something," whether the "do something" is give medication, put him in the hospital, do some tests, they are saying that the problem is serious enough so that they can no longer cope with it; that whatever their internal resources, the stress and strain is beyond them.

That is, I think, a role that parents should take. I think that is a very different question from what is the best kind of treatment approach once one has identified that either a child or adolescent or a family is in trouble

Q. Dr. Messinger, could you describe in terms of its effect and its nature the differences between institutional (119) treatment of psychiatric problems as opposed to community facilities?

In other words, why might there be a desire or a belief on your part as a psychiatrist that institutional care might merit different procedures than non-institutional care?

A. Let me try to answer that first by citing the advantages to a practicing child psychiatrist of working in a community facility and obviously in my own professional work, that is where I have chosen to be and then, to talk about some of the disadvantages or even dangers of institutionalization.

The advantages of working in a community facility are that one can readily be in touch with the child's family, with the child's school, with interested relatives or friends, with a variety of community leaders or helpers.

For example, a counsellor in an after-school recreation center. Even a store-keeper who has a friendly relationship with a teenager who most other people can't stomach, but one has access to what we call in psychiatry, "the social support system," and can bring our weight to bear on strengthening that social support system.

In practical terms, the institution that (120) usually blows the whistle on trouble for a child is the school, because of truancy, academic failure, misbehavior in the school.

If one works in a community facility and sees the child there, then one can—and I do these things—go to the school and talk with the classroom teacher, talk with the guidance counsellor and principal and if necessary make arrangements for transfer to another classroom, transfer to another school or transfer to a specialized school that will handle a youngster with whatever problems they might turn out to have.

Some other advantages—well, let me go to some of the disadvantages of institutionalization.

One is rooting the child out of the family and community, starting with the situation of excluding the child

from the family. I am not saying that that is never necessary. In extreme cases, it is. However, because the child's symptoms are immersed with the problems of the family, if there are going to be real changes in that child, there have to be concomitant changes in the family.

If the child remains at home for treatment, then one can work with both sides of the equation together. If a child goes to a state hospital, for example, for three months and then returns considerably improved, the (121) likelihood is that because of unresolved difficulties with the family, there will be a reoccurence of those problems. In terms of being uprooted from the community, it means at least that the adolescent who returned three months—I use the figure three months as a rough average for how long adolescents spend in hospitals—the child will return in three months time to his or her neighborhood school and there will be very difficult problems in readjustment, the embarrassment of meeting peers who ask, "Hi, Joe, where were you?" What is Joe to answer—"Well, I was in the State Hospital."?

It is a difficult situation to impose on the child. There is at least temporary loss of the social support system that I spoke about earlier.

Now, in terms of the dangers and drawbacks of institutionalization per se, I feel on very firm grounds, because I think that the entire field of psychiatry has been sensitized to the dangers certainly of long term institutionalization. In a sense, the derailment from the usual course of one's life, the dreary regimen even in the most progressive hospitals, the extreme deprivation and limits, including simply going where one wants to, dressing as one wishes, corresponding or communicating with friends, relatives, et cetera.

These are extremes. Then, too, the term, (122) "stigma" has been mentioned several times. I'd like to spell that out in somewhat greater detail.

I think there is a social stigma and I think there is a self-stigmatization that occurs, too. From a social and legal point of view, it means that that person, every time he fills out an application for college, the military, driver's license, hack license, et cetera, employment, is obligated in most states or at least in many states to state, "I have been a mental patient," and that is certainly going to give the school or the potential employer cause. While attitudes have changed slightly for the better in terms of some greater acceptance of the phenomenon of mental illness, they have changed very, very slowly and I don't know that we can predict in 1974 how employer "A", "B", or "C" is going to react to the fact that someone who asks for employment has been in a mental hospital.

Lastly, the fact of being in a mental hospital has profound repercussions in terms of that person's self-image and self-confidence. No matter how much they might wish to dismiss it as even an unfair event—and maybe it was—or "I got into the hospital only because my Aunt Tilly couldn't stand me"—it shakes a person's self-confidence to the core and I speak from experience in dealing with many patients who have been (123) through hospitals.

When they have been designated a mental patient, because no matter how scientifically and how manly we look at that phenomenon, there are traces of much older superstitions about it and we really do distrust the judgment of those who have been labeled "mentally ill".

Q. Dr. Messinger, as a result of the analysis of institutionalization, do you have any opinion as to whether

or not there ought to be a prior hearing in the non-emergency situation of a juvenile for commitment to a mental hospital?

A. I think there definitely should and I think that there should be in every case.

Q. Can you explain, if you will, the reasons that you believe that children ought to have a hearing?

A. There are many.

One is to sort out the facts. One of the prior witnesses said that lawyers are better trained to ascertain matters of fact than psychiatrists. I think that is true. I think we emphasize different kinds of data, but certainly, there should be the most careful gathering and weighing and discrimination of the facts of the situation. That is especially pertinent, because feelings tend to run high in such matters. One does not (124) have such a serious breach in family integrity, in family unity, without feelings running high and what happens most often is that there is a decided difference of opinion between the parental generation and the child or adolescent, as to what is going on and what the implications of this are.

For example, when Mary, age 16, asks to go to the school dance Friday night, that might mean to her, "I wish to meet some new people. I want to have some fun. There is someone there who I'm looking forward to seeing."

To parents, from their perspective it might mean, "She is out of control. We have prohibited her from going out; she should do her homework instead. What is going to come of her if we allow her this next freedom?"

What I am saying is from each parent's point of view, there is a very different assessment of the facts.

Q. Could you experience situations where the family misperceived or misinterpreted facts, which, if true, would have meant involuntary treatment for the child, but if not true would have meant no treatment for the child?

A. It usually does not hinge on a single matter of (125) fact. I think it hinges on a consistency type of coloring of the facts and what one sees as relevant in another person's life and from that point of view, yes.

Q. Parents do select things out that might in a way color the facts that are presented to the psychiatrist.

A. That happens almost inevitably.

Q. Dr. Messinger, could you please describe, if you can, what benefits, almost in a therapeutic sense, a hearing might have for a child, a prior hearing?

A. I think the major one is that a child wants to be treated fairly and that a judicial hearing is just that kind of impartial way of the facts and objective decisions as to what is best done about them.

Q. What effect would that have on the treatment that might occur if the child was ordered to have treatment?

A. I would agree with I think it was—well, both the prior witnesses, that that frees up the treating psychiatrist whether in an institution or outside of it, to do the treatment, help the person sort out their feelings and thinking about their life experiences.

If I am in the dual position of incarcerating a youth and also of asking him, "How do you feel about being incarcerated," I am in an untenable position. That has been recognized in settings where administrative decisions are separated out from psychotherapeutic (126) responsibilities.

So one psychiatrist wears the hat of administrator and another as therapist and I can't imagine that there would be any harm in the facts as they are being laid out before the child.

In fact, I think that it would give him pause and might lead him or her to reassess their opinion.

Q. With regard to the possible delay prior to a hearing in an non-emergency situation, do you feel that that delay would mean in your opinion that there should not be a hearing or what do you mean would be the advantages or disadvantages in such a delay?

A. I don't see any disadvantages.

I think in fact that the situation is somewhat safer with children who will either be living at home and thereafter are under some scrutiny—

Q. Safer than with whom?

A. Safer than with adults.

This is the situation with adults in the state of Pennsylvania. If the danger considered is, what if the situation becomes deteriorated and becomes more dangerous?

I think we are on safer grounds with children, because they are under the scrutiny of the parents or if they are in a foster home, the foster parents and (127) usually the school, too. If the situation deteriorates badly, then there could be a reconsideration as to whether it has become an emergency situation, but I would underscore the statements of both the prior witnesses that there are major and dramatic shifts in the behavior of adolescents. If there is anything that characterizes the behavior of adolescents it is that they are changeable and that very bad situations can right themselves.

There is another factor here and that is, once a family comes to psychiatric or a social agency's attention, efforts can be made to help the parents better cope with the situation. That, in and of itself, might give the adolescent another opportunity to regain their psychological equilibrium.

Q. Dr. Messinger, I would like to ask for your opinion and comments on some of the facts that have been agreed to in this case with regard to one of the named plaintiffs in this lawsuit.

MR. FERLEGER: Just for the Court's reference and Mr. Roth's reference, paragraph 21 of the final prehearing order with regard to Leslie Levine, Levine's parents are divorced. Her father's remarried and living in family. She would have at the time of her commitment, at the time this action was filed, liked to have been with her father because she gets along well with him.

(128) Every time she visits with her father her behavior is excellent. Levine's difficulties in relating to her mother resulted in her commitment.

Hospital records indicate that Levine threatened the lives of her mother and sister and that she has "a personality disorder".

Q. I wonder if you can comment as to whether or not this is typical, that an adolescent's behavior might change so dramatically with the environment, here with the father she acts one way and with the mother she acts another way.

A. The answer is, yes, that that is typical. It is typical of adolescents and it is typical to some extent with all people, that who we are is a function of the social setting.

By the way, I think that that has relevance to the question of procedures to be undertaken before hospitalization, that if an adolescent is brought to a psychiatrist, let's say, in the admitting room of a hospital or even to a psychiatrist in a community clinic, such as my own, but knowing that the parents wish to commit that adolescent, that the social context will have much influence how the adolescent behaves.

For example, the adolescent might say to himself or herself, "I'm up against the wall. Mother (129) and Dad want to send me off to the State Hospital and here's the strange psychiatrist who I have never met—" and God knows what their fancies are about psychiatrists in general— "I better not open my mouth for fear it will make matters worse," or they simply will say, "This isn't fair and they are against me," and it sounds paranoid.

If that child was able to see someone who they knew was their advocate in a different setting, they might present a lot more information and a lot different sounding information than in, you know, the other settings.

To return to the example, though, I think that that example demonstrates that there are legitimate differences of opinion and interest within a family. Sometimes, as in that family, it is between two parents and the child happened to side with one, versus the other. One would have to ask why does she have the personality disturbance when living in Pennsylvania, but the disappearance in Florida. Oftentimes, though, the conflict of interests is between the parent generation and the adolescent, because they have very different attitudes, experiences and values. The question is not who is right, but the question is that this is a very real and sometimes extremely intense kind of conflict between the two generations.

(130) Unfortunately, and I think that this is very dangerous, the parents can sometimes utilize psychiatric authority to deal with the issue and the psychiatric authority can either say, "Yes, you are right, long hair and smoking marijuana is evidence of mental illness," and might go another step further and say, "This is a dangerous situation; the child ought to be in a psychiatric hospital."

We have to remember that in psychiatry, except for neurological diseases, we are dealing with behavior and the behavior that we are most concerned with is social behavior. That is how an individual influences or affects another.

Most often, the social system that we are concerned about is the family. It is—hospitalization is rarely done because of mental illness, per se. It is done because that person's behavior, whether you want to call it mental illness or not, in a way is beside the point, adversely affects, disrupts, angers, upsets, challenges, the interests and attitudes of the people that they impinge on.

Q. With regard to the regulations of the state as adopted, which involve an evaluation at a base service unit of one facility in Pennsylvania and then an evaluation at a state hospital, the facilities where the person is to be committed, do you see any difficulties with those (131) sorts of procedures?

A. Yes, I do.

Q. What are they?

A. For one, some of the concerns that I have had about, for example, the adolescent having the setting and whether the adolescent feels that this is the place where he can open up an share his true feelings as to what happened, I think that might be as true in a community facility as in a state hospital admitting room.

I know that from my own experience in a community clinic, it often takes months to really get to know a child, for them to open up and for me to gather data from the family, school and child that will give me a rounded and balanced view of the situation.

Q. So, you think that the evaluation that those regulations require might not really get the information needed to make a recommendation?

A. That's correct. The data we are dealing with is not hard scientific information.

You can't read a meter and the dial rests at one place or another. You need to gather information, sometimes the most personal, intimate and disturbing kind, about not only one individual, but a group of individuals, and not only about that one family, but their relationship to the community and school in which (132) they live. This is a painstaking and complete process. That was one of the reasons that I think a hearing would be in order. It slows down the momentum.

Q. Now, Dr. Messinger, do you see any difficulties with the state hospital confirming the recommendation of the referring psychiatrist?

A. I do, because psychiatrists are people, too, and we are influenced by considerations other than those that are strictly clinical.

For example, if I, as director of a state hospital get a letter from a colleague in a community facility, saying that John Doe really needs psychiatric hospitalization and is serverely disturbed, even if I felt otherwise from a direct discussion with the patient, I would be in an awkward position if I said, "No, this patient does not require hospitalization."

What do I then say to my colleague whose opinion I disagreed with?

Secondly, professionals—psychiatrists who work for institutions, are influenced by the needs of the institution, as well as the needs of the individual patient.

If I am the director of an adolescent service and the funding of my unit depends on how fully utilized the unit is, I might be on the side of admitting (133) the adolescent. I am not saying this is done deliberately, but I think that a decision as complex as hospitalization is influenced by factors within the psychiatrists at a number of different levels and such considerations as bed utilization will play some role.

Thirdly—

Q. Doctor—

A. There is another consideration.

Most of the data that we use in making a clinical assessment of a child, comes from the parents. We usually do not depend all that much on the child or adolescent giving us a full, detailed view of their life, so that the information that largely influences the first psychiatrist's decision will be the information that largely influences the second psychiatrist's decision.

From that point of view, I think it is—necessary to bring in—it is preferable to bring in someone from a different discipline, namely a lawyer, and working in a very different kind of setting.

Q. Now, Dr. Messinger, do you see any reason why there shouldn't be a hearing for younger children who might not object in their commitment?

A. I think in fact that the need for a hearing in the younger children is greater, because one cannot expect them to understand fully, certainly in legal terms, their (134) dilemma, nor can they be aware of alternate forms of therapy.

Now, obviously, the form of such a hearing and how the child is to participate in it will be a matter for, I think, very delicate—very delicate concern. I think that most any child can have some meaningful input into a discussion of his or her future.

The input from a five year old will be very different from a nine, thirteen and eighteen year old. One cannot ask—one has to speak the language of the child and listen to the language of the child, but I think that because younger children are less sophisticated and less knowledgeable, that we have to bend over backwards to protect their rights.

Q. Now, Dr. Messinger, do you see any difficulties with the state's provision of a hearing after commitment, especially for a child who might after a hearing, be found not to have been in need of commitment in the first place?

A. I think it is a most inadequate provision and it is closing the barn door after the horse is out. I think it is disastrous to hospitalize a child and then find out, by golly, it wasn't necessary. That is playing with a child's life.

Q. Dr. Messinger, the regulations also provide that (135) once the child between 13 and 18 is placed in an institution, that the child may then raise an objection after being read a notice that he or she may do so. Do you have any opinion with regard to the validity or the possibility of objections being raised at that point?

A. I don't understand the question.

Q. Once the child gets read the notice of his or her rights, that they may object and then obtain a hearing, do you see any difficulty with the validity of the possibility of the child raising that objection once the child has already been in the institution?

A. Possibly—let me think this out.

One is that the child is then in some wise at the mercy of his keepers and might tend to simply accede to their point of view.

Secondly, there is a kind of indoctrination and I am not using the word in that sense exactly, but there is a kind of indoctrination that occurs whenever a person is in an institution. The kind of indoctrination that we psychiatrists do is to say to somebody in a mental hospital, "You are ill. You have personality difficulties within you. You need treatment." And almost universally it is said, "The treatment that you need is the treatment that we are providing."

So, this I think also would make it more (136) difficult for the adolescent to say, "No, wait, I see things entirely differently."

Q. Dr. Messinger, just to finish up a few miscellaneous points, is it your opinion that adolescents can or cannot apply for admission to facilities on their own or ought they to have the parents' consent or advocation?

A. That is a delicate question.

I would like to see adolescents be able to obtain psychiatric treatment as out-patients and even as in-patients, because they felt it was necessary, if indeed the psychiatrist agreed—

Q. Of course.

A. —because there are instances that the adolescent is troubled and knows it and the parents have a need to deny it.

I am not in favor of doing this behind the parents' back. You know, I am a parent myself and I want to know what is happening with my children. I know that there is a trend towards giving adolescents greater discretion about seeking medical treatment on their own and I would hope that that would be extended to psychiatry.

In fact, that is done; it is done.

Q. Dr. Messinger, what is your opinion with regard to whether or not the involvement of a lawyer as Counsel for a child would interfere with the ability of the child (137) psychiatrist such as yourself to deliver needed services to juveniles?

A. Could you be more specific as to how it would interfere, because offhand, I don't see how.

Q. I am asking you whether or not you feel it would interfere?

A. I see no reason to think so.

MR. FERLEGER: No further questions at this time.

Cross-Examination

BY MR. ROTH:

Q. Dr. Messinger, I will just ask you a few questions.

Are you opposed to institutionalization?

A. I think that hospitalization or institutionalization for example, in a facility for mental defectives, should be

a last resort and that as much work as possible, as much effort as possible should go into finding some other resolution of the child's and family's difficulties.

I have recommended hospitalization for children and adolescents when I thought that all other remedies had been used.

Q. Then, is it my understanding that you feel that institutional treatment is a good treatment program, if the institution is rendering good treatment and the child needs institutional treatment; you have no problem (138) with that concept, then?

A. Correct.

Q. Didn't you, in fact, write an article, "A Psychiatrist's Views of Institutional Treatment of Young Adult Offenders," in 1965?

A. I wrote the article.

Q. Doctor, you have testified about stigma. Let me ask you, to avoid stigma, would you not hospitalize one in need of such?

A. It is like so many of these questions, a matter of judgment and in weighing whether someone should be in the hospital or not, I would consider, and particularly for a younger person, what effect will this have on his later life, because a move done at a certain point in that person's life, while it seems judicious then, might later turn out to have harmed him and there are examples of a person who entered the hospital sometimes on their own for a two month period and then wanted to go to medical school five years later and was denied admission.

I guess one can argue one way or the other as to whether that initial psychiatric hospitalization was in the overall long term best interests of that person or not. I

am just saying that we have to be cognizant of the enormous social toll that institutionalization brings.

(139) Q. Fine, I appreciate that answer.

The question still remains, Doctor, to avoid stigma, would you not hospitalize one who is in need of hospitalizaion, who requires that and that's the only form of treatment that can be given, because other treatments have been explored, but they are not acceptable for treating the person at that particular level?

MR. FERLEGER: Objection. He has just answered that question.

JUDGE GIBBONS: No, he did not.

Overruled.

A. If the person requires to be in the hospital, then, they require to be in the hospital and I would assist in that.

Q. But the question remains, to avoid stigma—

JUDGE GIBBONS: He has answered that question now. Pass on to something else.

Q. With regard to patient Leslie Levine, whom you addressed yourself to, are you aware of the personality disorder of Leslie Levine?

A. I know no more about Leslie Levine than what the Counsel read.

Q. Now, you have testified that institutional psychiatrists do not become involved with family orientation.

Is that true in Pennsylvania? Are you (140) aware of that in Pennsyvania?

A. As a rule, and I have not spoken to psychiatrists who work in Pennsylvania state hospitals, as a rule, psy-

chiatrists who choose to work in institutions do not have a strong commitment to a family outlook on psychiatric problems.

Q. Do you have any statistics to buttress that statement, any articles?

A. In a negative sense, yes.

I know that those who worked in such institutions do not write articles about the family aspects of psychiatric problems.

MR. ROTH: Your Honors, I have no further questions.

JUDGE GIBBONS: Dr. Messinger, you spoke about the possible therapeutic benefits of a hearing, precommitment hearings for the child, because the child wants to be treated fairly.

Is there any empirical data as to how children perceive the judicial process?

THE WITNESS: I don't know any.

JUDGE GIBBONS: In the absence of such data, how is it possible to say that the child will receive a therapeutic benefit from a perception of being treated (141) fairly, if in fact, the data suggests that children perceive the judicial process as hostile and unfair.

Would your conclusion of a therapeutic benefit still follow?

THE WITNESS: I am not happy with the term "therapeutic benefit". I believe it should be done, because it should be done, to protect the interests of

the child. I believe that if it is explained properly to the child, they could understand that the judge is a person who will try to find out what is the matter and what is best to be done and that that judge is not—is a different kind of adult than a parent.

JUDGE GIBBONS: Is the process of explaining, with respect to the judge's role, any different than the process of explanation with respect to the psychiatrist's role?

THE WITNESS: I am not sure if—

JUDGE GIBBONS: You spoke of the duality of the role of the psychiatrist.

THE WITNESS: Yes.

JUDGE GIBBONS: Wouldn't the same explanation serve that purpose? That is, serve the purpose of removing from the child's perception the thought that the psychiatrist was somehow his enemy or persecutor?

THE WITNESS: Indeed, I think it is a fact (142) that a psychiatrist who works for an institution does have a dual allegiance and I don't think that the judge who sits on such a case does.

JUDGE GIBBONS: You testified that most of the data that the psychiatrists rely upon under the Pennsylvania dual interview system comes from the parent.

Is it your perception that in a judicial proceeding the Courts would be more able to get information from other sources than the psychiatrists?

THE WITNESS: I would assume so.

JUDGE GIBBONS: Why do you assume so?

THE WITNESS: I might be in error, but I would assume that the authority of the Court might be such that they might, for example, obtain information about the family, that the family would not voluntarily impart.

For example, if parents have committed another child or have been accused or tried for child neglect or have criminal records or the like.

I might be wrong about this, but I assumed that the Court would have authority to obtain such information while the psychiatrists, we are only able to hear what the person wishes to say.

JUDGE BRODERICK: Doctor, I just wanted to clarify one thing.

Other than what we have been referring to (143) as the "emergency situation," are there any cases where you recognize, in connection with the treatment of juveniles, that the in-patient care is preferable to the out-patient care?

THE WITNESS: Yes.

JUDGE BRODERICK: What would one of those be, for instance?

THE WITNESS: It came up recently with a 14 year old boy who I had been seeing on and off in the clinic for the last four months or so.

It so happens that his hospitalization occurred during a time when I was on vacation and the police

had to be called. However, I was considering hospitalization for him and had shared that fact with both him and the parent.

Without going into the details, I think the considerations here were the severity of the pathology, the possible danger of the pathology, how chronic it was and most importantly, how poorly motivated the boy was to obtain treatment.

So, when I and others at the clinic offered him a variety of approaches, medication, sessions, counseling sessions, a summer program, a change in school, he turned his back to all and I had to tell him, "You are forcing the issue and you will have to be hospitalized (144) if you don't make yourself more receptive to things that we might try on an out-patient basis."

As I said, it so happened that he, in a sense, decided that matter in my absence, but I would have hospitalized him.

JUDGE BRODERICK: In his particular case, do you see where there may have been an advantage to have a court hearing to determine his commitment?

THE WITNESS: I think the advantage would have been then, not only I as his psychiatrist, but a separate adult in weighing the evidence came to the same decision and if the judge did not, then I would have to ask myself, you know, in what way did I error and how can I re-examine and revamp my treatment planned, so that it is more effective for this child.

JUDGE BRODERICK: What would you perceive in your view of a judicial hearing for that

young man; what would you imagine would have taken place?

JUDGE HUYETT: Could I add something to that?

What would be the issues of such a judicial hearing? What issues should be decided?

THE WITNESS: I think first of all, an agreement on what are the facts.

Secondly, some assessment of how severe (145) the pathology or disturbance of the child is.

Thirdly, how dangerous the situation is, or might become.

Fourthly, what else has been tried and what else might be tried.

Fifth, what the adolescent himself says about the matter and what he thinks might be best for him, and, sixth, what the family thinks would be best for the boy.

JUDGE BRODERICK: But in that situation, as you would apparently envision that you would testify as to what your opinion is?

THE WITNESS: Yes, I think I would testify as to the facts as I knew them, my experience in working with the boy, something about diagnosis and making a recommendation.

I think the advantage there would be that if the child were then hospitalized, when he came out of the hospital and returned to our clinic, which I think is the only psychiatric facility available in that neighborhood, I would then resume the treatment without my having been in the role of his—the guy who sent him away.

JUDGE BRODERICK: In that situation and I am still talking about the same young man being (146) represented by an attorney at a hearing, would it not be incumbent upon his attorney to perhaps try to find a psychiatrist who would take the position of the child, if he didn't think he should be committed?

A. Yes, I would hope that that would happen, because we are not dealing with black and white matters. We are dealing with very complex—with people who are complex and situations—human situations are very complex and I would want, if there was another professional who took an opposing viewpoint, I would want that viewpoint presented.

JUDGE BRODERICK: Thank you.

MR. FERLEGER: No further question, your Honor.

MR. ROTH: None, your Honor.

(Witness leaves the stand.)

JUDGE GIBBONS: Do you have any further witnesses?

MR. FERLEGER: No further testimony.

With regard to the plaintiffs' Exhibits, I would like to move for the admission of Exhibit No. 1, which are the affidavits of the two juveniles, regarding which Mr. Roth, this morning, was granted ad-

mission of his counter affidavits and I don't believe there is any objection to that.

(147) MR. ROTH: No objection.

JUDGE GIBBONS: Will Counsel take care of marking it afterwards and we will get on with the testimony afterwards.

(Whereupon two affidavits of juveniles were marked plaintiffs' Exhibit No. 1.)

JUDGE GIBBONS: I take it you are offering Dr. Messinger's Curriculum Vitae?

MR. FERLEGER: Yes.

(Whereupon, the Curriculum Vitae of Dr. Messinger was marked plaintiffs' Exhibit 5 in evidence.)

MR. FERLEGER: With regard to two and three, Judge Huyett said we would be able to present them to you—

JUDGE GIBBONS: Does it make any difference whether we rule now?

MR. FERLEGER: No difference. I would be willing to renew this motion at the end of the testimony.

JUDGE GIBBONS: You have made your offer and we will consider that.

MR. FERLEGER: Thank you, your Honor.

JUDGE GIBBONS: Do you have a witness?

MR. FERLEGER: Yes, your Honor, we do.

LEVON DONALD TASHJIAN, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Levon Donald Tashjian.

(148) *Direct Examination*

BY MR. ROTH:

Q. What is your profession?

A. Medical doctor and psychiatrist.

Q. Are you licensed to practice medicine and psychiatry in the Commonwealth of Pennsylvania?

A. Yes, I am.

Q. Where did you obtain your license, please?

A. I went to medical school at the University of Pennsylvania, interned at Pennsylvania Hospital and obtained my Boards.

Q. Where are you presently employed?

A. Institute of the Pennsylvania Hospital.

Q. Doctor, where did you perform your residency?

A. Jefferson Medical College Hospital and Hospital of the University of Pennsylvania.

Q. What specialities do you pursue?

A. I am Board certified in psychiatry and my specialty is adolescent psychiatry.

Q. How long have you been practicing?

A. For over eight years. That is, eight years following colleges of residency.

Q. What has your role been at the Institute?

A. From 1968 until July of this year, I was associate director of the adolescent treatment center at the (149) Institute, and since July, I have been director of the young adult program and unit at the same hospital.

Q. Are you the recipient of any awards?

A. Yes, I am. I think listed there is the Sol Ginsburg Fellow, for the Group for the Advancement of Psychiatry.

MR. ROTH: Do you have any cross-examination?

MR. FERLEGER: No.

MR. ROTH: Your Honors, at this point, may I introduce to the Court the Curriculum Vitae?

JUDGE GIBBONS: Yes, what is your next number?

MR. ROTH: I am not sure which Exhibit number it is.

JUDGE GIBBONS: You will take care of giving it a number and let us know.

MR. ROTH: Thank you.

Continued Direct Examination

BY MR. ROTH:

Q. Doctor, have you participated in the admission of juveniles at your institute?

A. Yes, I have.

Q. Would you please explain how a juvenile is admitted at your institute?

A. Fine, let me explain—first of all, give a general overview and then give a view of my procedure of evaluation of a juvenile.

(150) In general, the Institute, which is a private psychiatric facility, receives patients upon referral either

from a base service unit, other institutions or from private referrals in the area.

They may come from within the Philadelphia area or they may come from as far away as the West Coast.

So most young people who come to the Institute, come having been seen prior to arriving at the hospital.

Before anyone can be admitted to the Institute, they have to be seen and evaluated by one of our attending staff at the hospital and then he either concurs or disagrees on the question of admission for that young person and at the time of admission, the young person and his family are seen again by at least the resident psychiatrist prior to admission and then, in the days following admission, and I am talking about 24 to 48 hours, he is seen at least by one and often more likely a half dozen other psychiatrists who are members of the staff of the Institute.

Now, my procedure and I think it is important to mention this, in evaluating a young person, is as follows:

Parents will often initiate the request for evaluation and they will often come to me requesting (151) or stating that their child is mentally ill and requesting hospitalization, but simply because a parent requests hospitalization is no reason that of necessity we will go along with hospitalization as a part of my evaluation, my standard procedure is to first of all see the child with his parents and preferably with any other siblings, if they are available or can be brought in for that evaluation and then next, I would like to see the child individually, alone, and then I would like to see the parents alone, and finally, in this four-step procedure, I would like to see the entire family together, prior to my deciding on the question of admission to the hospital.

Now, in case of pressure of time, this process may be established—may take place during one day and even in the most serious and complex instances, it might require a couple of hours to make this evaluation. Where there is more of a luxury of time, we may stretch out this evaluation over a several day period.

Only when I have made such an evaluation, will I recommend or not recommend hospitalization.

Q. Doctor, what percentage of those juveniles whom you see, do you advise institutionalization for?

A. I think 60 to 70 percent. Roughly 30 to 40 percent of those who are brought to me or come to me for evaluation, it is my recommendation that other forms of treatment or (152) occasionally no treatment should be the choice.

Q. And, have you had situations where the parent insists on institutionalization?

A. Yes, I have, in the face of my not recommending institutionalization. Is that correct?

Q. That's correct or in the alternative where they indicate at the outset they want to put their child into your institution.

A. Yes.

Q. And, what do you do then?

A. If I do not feel that the young person demands or needs hospitalization, I certainly will not admit that young person even if the parents are absolute in their demands.

Q. Just traveling along this path where the parent comes with his child, do you find that the child generally objects to being admitted when you are recommending admission?

A. We are talking now about young people who are evaluated and are deemed in need of hospitalization?

Q. Yes.

A. I think our adolescent unit admits between 60 to 75 patients per year and since its inception in 1966, it has done this, and depending upon whom you talk to, between 90 and 99 percent of those adolescents admitted to the (153) hospital object and at the time of admission, to admission. So, we see that the percentage of those who object is very, very high.

Now, one must evaluate carefully the nature and the quality of that objection, and one must see, if I can make some generalizations about the common aspects of those objections.

First of all, a young person is liable to be frightened, absolutely frightened by the thought of his having a mental illness and by the thought of his having to go into a hospital, a mental hospital, and we all know what stereotypes there are that abound about mental hospitals, asylums, looney bins, et cetera.

Secondly, young people, adolescents, are in the stage of development where they are in the process of separating and individualizing themselves away from their parents. away from their family of origin, and any number of writers in the field, experts in the field, have commented on the fact that essentially in this process of separation, et cetera, the young person uses the defense mechanisms of projection and externalizations, that is, commonly, he blames his faults upon the world, whether they be the world of his parents or the world of his family, the world of his school or the world at large and so, commonly, you will hear the young person (154) say that it is not he who

should be here, but it is his parents or it is—commonly, the parents and occasionally a sibling. These are two general themes that commonly underly the objections that a young person brings with him.

Q. Doctor, are you familiar with the juveniles who have been admitted to the Institute of Philadelphia in the past two to three years?

A. Yes, I am.

Q. Are all the admissions of these juveniles reviewed with you?

A. Most of them, certainly, yes.

Q. Doctor, have I advised you that the Department of Public Welfare sent a questionnaire regarding admissions of juveniles to mental health, mental retardation facilities, last year?

A. Yes.

Q. Have I advised you that one of the questions asked was: "What was the reason for the juvenile's admission or commitment or precipitating behavior warranting admission or commitment?"

A. Yes.

Q. Have I indicated that we received, briefly, responses from your Institute?

A. Yes.

(155) Q. Have I asked you to review the admissions of these juveniles?

A. Yes, you have.

Q. I would like to refer to the prehearing order and in particular to page 15, where it was indicated, "Children have wound up at institutions for the following reasons in addition to their being mentaliy retarded" and with reference specifically to the Institute of Philadelphia Hospital, Dr. Tashjian, could you please indicate the nature

of the admission of 949433, where the reason given by the Institute is family conflicts?

MR. FERLEGER: Objections, your Honor, unless he has with him the patient's records which can be examined with a court order for confidentiality.

I don't see how unless he testifies that he has been personally involved with that patient and has some foundation that he can testify to that.

There is no way I can lay any groundwork for cross-examination about a particular patient.

JUDGE GIBBONS: What is the purpose of the offer?

MR. ROTH: Your Honor, I wanted to show that I believe there's been an implication made by plaintiffs that, based on the description of the precipitating behaviors that was the sole reason and there is (156) nothing beyond that and I wanted Dr. Tashjian, who has already testified that he has reviewed the juveniles that he was the associate director for of the adolescent unit whereby these juveniles came through his review, and I wanted him to testify with regard to any conditions that may have warranted an admission.

MR. FERLEGER: If I may respond, that point of view was raised in Judge Huylett's chambers and Judge Huylett ordered that Mr. Roth supply a sample of 10 fuller records which he has already supplied and which we don't object to, so whether or not the statement reflects, the reality is so.

MR. ROTH: I am not trying to bring in record of other patients. I am not trying to say one was exclusive of the other.

When we were before Judge Huylett, as I recall, plaintiff and I had agreed that we could select the profiles of 10 patients with regard to pre-admission notes. At that same time, I don't think I excluded the possibility of have any expert witness testify as to the reasons of the admission of any juvenile.

JUDGE HUYLETT: Would you gentlemen indulge us for just a moment, please?

JUDGE GIBBONS: I don't think we need detailed testimony on this particular case. The prehearing (157) order provided for the production of the 10 samples and I think for the purposes of this lawsuit, that is sufficient.

MR. ROTH: All right.

Continued Direct Examination

BY MR. ROTH:

Q. Doctor, let me ask you this with regard to admission of patients in your Institute.

For example, if a patient comes in and one of th problems seems to be weight loss, what other reasons could be indicative of the admission of that patient?

A. Let me first respond in a general way that th reason for admission, and this is something every medical student is taught, during his first and second year of medi

cal school in history-taking is, a composite of the patient's chief complaint which one must take down verbatim, so if you ask the patient, "What brings you here?", and the patient responds, "The trolley.", the doctor would put down the concrete inappropriate response of "The trolley" for chief complaint, and then the physician would sometimes use a few words to describe reason for admission.

Now, it may be because of—let me use a general medical example first before I get to the psychiatric example. It may be for bellyache or abdominal pain. So we have that as the reason for admission—abdominal pain let us say. That can vary all the way (158) from abdominal pain secondary to a hangover from the night before or from having eaten hot peppers to an inflamed ulcerous state and it runs a wide gambit, so to respond to your question specifically about weight loss, that in and of itself that as a reason of admission is drivel unless clarified and amplified.

There are serious—extremely serious, life threatening psychiatric conditions which have as their presenting complaint weight loss.

Q. Would that necessarily hold true for children who come to you that are labeled "runaways," or in conflict with their parents or anything of that nature?

A. Absolutely.

Practically every family with teenage kids knows what it is to experience conflict and in and of itself, family conflict is universal. One has to evaluate the quality of that conflict, the degree of that conflict, the lack of resolution—potential resolution of that conflict and to go back to my evaluation as I said, of an adolescent, that would include

evaluation of family members. It would include looking to what the parents bring to the situation that impinges upon the young person who is designated as the patient or patient-to-be and at times it may be tremendous.

Q. How do you distinguish non-emergency from emergency?

(159) A. I think the Mental Health and Mental Retardation Act of 1966, states that if a person is suicidal or homocidal, that qualifies as an emergency condition.

So, in argument from that standpoint, everything else falls into a relative non-emergency situation, but within non-emergency situations there are those situations where one has the luxury of time on the one hand and on the other hand, there are those situations where one really does not have the luxury of time—where something must be done posthaste—lest the situation escalate or inflame into a potential emergency situation.

Q. In your opinion, Doctor, do you see any advantage of having a parent admit his child to the Institute or in the alternative, having to undergo a judicial proceeding, whereby the parent and juvenile are acting in adversary roles of one another?

A. Again, I want to clarify, and this may seem like nit-picking, but the parent, maybe in a legal sense, does admit the child, but in a psychiatric medical sense, does not admit the child.

The child does not come in because the parent wants the child to come in. The child only comes in after two individual evaluations, at least, and oftentimes in the young people that we are dealing with, they have had several evaluations. They have also had trials (160) of treatment

elsewhere before they are brought to the Institute, before that is considered. I think this;

I will go back to what I said earlier, that 90 to 99 percent of the young people who are admitted to the adolescent treatment center protest in some form or another.

Now, I am sure that if we were to offer—if we were to offer the possibility of having an adversary type hearing, if that was available prior to hospitalization, that a good percentage of those might elect such a hearing, but what happens, once the young person is in the hospital and immediately upon hospitalization, he is informed of his rights in a humane manner by members of the staff and according to Title 55, we carry that out to the letter, that once a young person is hospitalized, of the 90 to 99 percent who objected prior, the overwhelming majority have accepted hospitalization and give up their protests, even though the free legal counsel is available to them just for a phone call, and a free phone call at that.

Now, why does this happen? It happens for a number of reasons. One of them being that most young people are ambivalent in terms of their needs to be hospitalized. Most young people, where the admission is appropriate for psychiatric reasons—again, if I can digress (161) for just a second—no, I will come back to that later, excuse me.

There is an ambivalence and once, in a sense, put into a situation, then a large part of the struggle is over. Once a young person also gets into a situation and finds it is not such a fearful situation, that he is going to be treated humanely, and once the young person has the opportunity to talk with other young people, his peer group.

who are hospitalized there themselves, that these are some of the factors that we think significantly cut down the degree of objections that take place among hospitalized adolescents within the first 24 hours of hospitalization.

Q. Do you feel that juveniles should be able to admit themselves?

A. No, I do not.

Q. Why do you feel that they should not be able to admit themselves?

A. I am aware of Senate Bill 1239, Senator Coppersmith's bill. I have participated in helping to shape that bill and I am aware in that bill in dealing with minors, there is the question of whether 14 year olds should be looked upon as if they had reached their majority, and again, from a psychiatric standpoint a 14 and 15 and 16 year old has not really reached his majority; that in the process (162) of his development, in the process of his separating himself off from the family of taking an individual autonomous stance with himself, some of the things we lump together under the general rhetoric in the process of his developing his personal sense of identity, the young person is in conflict commonly with his parents and I would point out to you that how many of us sitting in this courtroom were not at some point and at time maybe in a major way in conflict with our own parents in the process of growing up and how we now look back upon that conflict.

I don't feel that minors have the judgment to decide for themselves when they want to see a psychiatrist and when they don't want to see a psychiatrist. I feel that they can aid and collaborate in that judgment. I feel that they have a voice and that voice must be heard. I feel it is an essential voice, but I do not feel that a young person in

and of himself, by himself, can make a decision of that magnitude.

Q. If a juvenile presents himself or herself at your Institute and seeks help, what would you do?

A. Okay, what would I personally do?

There are some of my colleagues who might do differently. If that young person saw me—requested to see me, I would see him. For the purpose of ascertaining his complaint. If I felt his condition required (163) emergency measures, then I would attempt to contact his parents and any other authorities necessary to protect him. Whether that young person wanted me to contact his parents or not. I, personally, would not undertake to treat that young person unless he allowed me to make contact with his parents and to see his parents and have commonly, my experience to include his parents in the treatment. If we are going to talk about family systems, as the previous witness has, in terms of seeing the family system as the nucleus, then, it is important that we not allow any one member of that nucleus to fail, whether it be the young person or the parents.

Q. Have you taken part in the hearing for institutionalizing of juveniles?

A. Yes.

Q. Do you feel that hearing is traumatizing on the juvenile?

A. Yes. It damages what is usually a weakened family situation. It pushes that family to the wall even further. Oftentimes, when a young person is in distress and his family is in distress, there is a lot of acrimony, a lot of verbal violence, occasionally some physical violence and a lot of hate and in my experience, going to a Court and having an adversary situation escalates that.

The second point I'd like to make is what (164) is the Court to ascertain? It's been mentioned here that the Court is to ascertain the facts. Again, I am not comparing us with lawyers, but physicians from the early days in medical school are taught in history-taking and I did this both as a student and teacher when I was teaching medical students at the University of Pennsylvania, are taught to assess the reliability and validity of information gotten from the patient and other informants who talk about the patient.

When I talk with the parent and the parent tells me that Linda Sue wants to go to the dance, rather than stay home and study, I feel a competency to evaluate the truth of this and by the way, I am going to get Linda Sue in and have her respond to this and I am going to look at the equality of the complaint and sometimes I am going to hear some very absurd complaints.

I, as a physician and psychiatrist, am in a position to evaluate this. If the other point is in addition to facts, we are here to evaluate the mental status of the individual, something that is more intangible, something to be sure does involve judgments and is subject to error, but we are here to evaluate the motivation, the mental status and the whole emotional make-up that lies behind the behavior that the young person presents and the complaints that the family expresses and may have.

(165) So, again, we may have a young person whose reason for admission is that she is hospitalized because of family conflict and we would say, "My goodness. How unfair it is to do this." We have to go deeper; what is the nature of that family conflict? How is that individual, the so-called designated patient, affected by that family

conflict? How profound is her disturbance? How is it likely to continue if she remains within the confines of that family? Is there a possibility that one as an out-patient can get a hold of this family in treatment or the parents in treatment or does one make a treatment that one can't get a hold of soon enough and if one lets one go, might she not suffer great harm?

To use an analogy, someone is made very sick by, let's say, the escape of chlorine gas as occasionally happens here in Philadelphia and other places. Now, to deny that person hospitalization, because the reason for admission is chlorine gas, when you really want to get and bottle up the cannisters of the train cars of chlorine is absurd. One has the responsibility to protect and to treat the individual once one makes a decision that that individual is suffering from severe emotional disturbance whatever the causes are.

Q. Doctor, your Institute, I would assume, is fairly expensive per day; is it not?

(166) A. Yes.

JUDGE HUYETT: What are the daily charges, roughly?

THE WITNESS: Roughly in the area of $110.00, $120.00, $125.00 a day. I must say it is not—well, that sounds defensive. I'll let it stay.

Q. Have you ever found yourself in a situation where a patient required in-patient care at your Institute, however, the family finances or insurance coverage was not able to meet all these costs and you had to recommend another institute or an institution?

A. Yes, I have.

Q. Have you ever recommended a state institution?

A. Yes, I have.

Q. And, what state institutions have you recommended?

A. Norristown and Haverford State Hospitals.

Q. Do you find that out of those institutions, when you refer a patient, that the patient is then evaluated by the staff at either one of those hospitals?

A. Yes.

Q. Do you find that at those hospitals, the psychiatrists are not only looking to the prospective or designated patient, but also they look to the family?

A. Yes, that's been my experience.

Q. What I am trying to get at, Doctor, as a private
(167) psychiatrist at a private facility, as you may have heard before, there was some claim that psychiatrists at institutions do not involve themselves with the family and look strictly or focus strictly on the designated patient; is that your experience?

A. I think what we are talking about as a new trend in adolescent and child and general psychiatry, of looking at the family system, which is a derivative of the so-called "general systems" theory and it's been my experience that this is common knowledge now to anyone in psychiatry who has been doing any reading at all in the last 10 years.

Q. Doctor, do you have any idea how many juveniles have objected since September of 1973, roughly in your institution?

A. Objected—

Q. To their admission—

A. To the point of contacting—

Q. A lawyer, yes.

A. Of let's say roughly 75 patients in that time, maybe a dozen have objected to the point of contacting a lawyer, and I think two or three objected to the point of going for a Court hearing.

MR. ROTH: I have no further questions, your Honor.

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(168) *Cross-Examination*

BY MR. FERLEGER:

Q. Dr. Tashjian, you mentioned charges of $120.-00—

JUDGE GIBBONS: Do you expect your cross-examination to be prolonged?

MR. FERLEGER: Probably at least 20 to 30 minutes, your Honor.

JUDGE GIBBONS: As I told you earlier, that won't be possible and since the Doctor would have to then return in any event, perhaps we should recess now.

MR. FERLEGER: Certainly, your Honor.

JUDGE GIBBONS: We will resume Wednesday morning at 9:30 A.M.

MR. ROTH: Dr. Tashjian will commence at 9:30 Wednesday, be the first witness and he will continue his cross-examination?

JUDGE GIBBONS: Usually, when I grant a recess before cross-examination, it prolongs the cross-examination. Think about that carefully.

MR. FERLEGER: Thank you, your Honor.

JUDGE BRODERICK: You mean you want him to be different or not to be?

JUDGE GIBBONS: It is usually not useful.

MR. FERLEGER: I will just note that I have given the Clerk, you might want to take with you, copies (169) of the deposition of Dr. Barbara Armstrong.

JUDGE GIBBONS: Would you take care of, today, of getting the Exhibits marked?

MR. ROTH: Yes.

(Whereupon, at 3:55 P.M., Court was adjourned until 9:30 A.M., Wednesday, September 11, 1974.)

EVIDENTIARY HEARING
SECOND DAY

Philadelphia, Pa., September 11, 1974
(9:30 a.m.)

Before:

Hon. John J. Gibbons, C. J.

Hon. Daniel H. Huyett, 3rd, J.

Hon. Raymond J. Broderick, J.

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(172) (All Counsel and parties being present, the following transpired in open Court.)

JUDGE HUYETT: Good morning, gentlemen.

JUDGE GIBBONS: Good morning.

JUDGE BRODERICK: Good morning.

MR. FERLEGER: Good morning, your Honors.

MR. ROTH: Good morning, your Honors.

JUDGE GIBBONS: Mr. Roth, are you ready to proceed?

Mr. ROTH: Yes, your Honor.

On Monday afternoon, we had completed our direct examination, as I recall. We have no further questions.

JUDGE GIBBONS: Dr. Tashjian, would you resume the stand?

(LEVON D. TASHJIAN, previously sworn, resumed the stand and testified further as follows:)

Cross-Examination

BY MR. FERLEGER:

Q. Dr. Tashjian, how many psychiatrists do you have on your adolescent unit at the Institute of Pennsylvania Hospital?

A. There are two sets of answers for that.

In terms of administrative responsibilities for running the unit, there are four Board qualified or Board certified psychiatrists. At least two and usually four residents in the second year of psychiatric training and there are a number of attending psychiatrists who are on the staff of the Institute who admit—

Q. How many are they?

A. Well, there are approximately 160 psychiatrists associated with the Institute.

Not all of these psychiatrists by any means work with or treat adolescents, and I would say maybe we draw from a pool of 30 or 40 attending psychiatrists.

Q. How many other treatment staff are there, approximately?

A. In the—

Q. In the adolescent unit.

A. We have a very large treatment staff. We have a certified and accredited school with a faculty of 12 to 15. We have multi-disciplinary recreational and therapy departments with a staff of four to five, plus a good complement of nurses.

Q. Your program there is a rather unique program in the city, isn't it?

A. We think so.

Q. And, I would guess from what I have heard, since we sought you as a witness for our side, that your program is rather unique in the country; would you agree?

(174) A. No, I think that there are—we think it is a darn good program and we will match it with programs—

Q. Is the program in most of our state hospitals for adolescents?

A. I think so; yes.

Q. You mentioned that you refer people who can't afford the $120.00 a day fee to Norristown State Hospital or Haverford State Hospital; is that right?

A. Yes.

Q. Do you refer people to Philadelphia State Hospital?

A. I have not had occasion to.

Q. Why not?

A. Because people—well, my patients—primarily, because those patients with whom I would refer have not fallen into that catchment area.

Q. Isn't it another reason that Philadelphia State Hospital does not have an adolescent program; it isn't such a good hospital to begin with?

A. I have no direct familiarity with Philadelphia State Hosiptal.

Q. What is its reputation?

A. It's reputation is pretty much as you describe it.

Q. Dr. Tashjian, I am asking these questions, because you testified about your procedure and you emphasized the word, "your" for admitting adolescents. You don't (175) have any knowledge of the procedures at Philadelphia State Hospital or other state hospitals around the

state, except for Haverford and Norristown; isn't that right?

A. In general, yes.

Q. Yes, you do not have knowledge?

A. Yes, that's true.

Q. So, that when you testified that you do a full-day evaluation, you do not know if the state hospitals or state facilities for the retarded which typically have fewer staff, you don't know if they are as extensive as you are personally in your evaluations; isn't that right?

A. No, I must say, if I can state this, that I do a fair amount of teaching and in the places that I do teach, I do recommend my form of evaluation as a standard form of evaluation.

Q. I understand that. I hope your students follow your recommendation.

Now, Dr. Tashjian, with regard to the replies that your Institute made to the defendants' interrogatories which will be part of the record in this case, you testified that you were familiar with those replies; is that right?

A. Yes.

Q. And, you are aware, are you not, that those replies indicate that in 1972, there were no Section 406 Court (176) commitments to the Institute; is that right?

MR. ROTH: Objection, your Honor.

Dr. Tashjian testified with regard to the particular patient profiles that I had alerted him to. He has not said on direct examination that he was aware of all the responses to that questionnaire.

MR. FERLEGER: Mr. Roth, can we stipulate that this is the response and no Court commitments were reported by the Institute of Pennsylvania Hospital in 1972?

To save time, let me withdraw that question.

Q. Isn't it correct, Doctor, that the Institute generally receives few Court commitments of juveniles, most of your patients are voluntary, signed in by their parents; isn't that right?

A. Most of them come in under a 403, rather than a 406.

Q. Most of them, as you testified, are people whose family can afford $120.00 a day, plus additional costs; is that right?

A. Yes, either because of personal monies that they have or health insurance that they have of one form or another.

Q. So, you do not have the experience with lower middle class or lower class people who form most of the patients in our state hospital system; is that right?

(177) MR. ROTH: Objection, your Honor.

It's not been established that lower socio-economic backgrounds are the primary persons who are in the institutions.

MR. FERLEGER: I think the Court can almost take judicial notice of the fact that people in state hospitals are not the people who can afford the $120.00 a day that the Institute charges.

JUDGE GIBBONS: No, I don't think I can. Sustained.

Q. Dr. Tashjian, you testified that 90 to 95 percent of the juveniles who are sought to be admitted to the Institute object to being there—

A. To being brought in there.

Q. To being brought in there?

A. Yes.

Q. Now, Dr. Tashjian, what proportion of those juveniles do you feel are competent to voice an objection?

MR. ROTH: Objection, again, your Honor.

I am sorry, it is misleading. However, Dr. Tashjian testified approximately 99 percent voiced an objection.

JUDGE GIBBONS: Well, 99, 95, of those who voice an objection, what percentage in your opinion are competent?

(178) THE WITNESS: I don't know what either of you mean by "competent." I'd like to answer that question, but I would like a clarification of what you mean by "competent."

Q. With regard to the individual case that you were going to testify about and with regard to your institution's responses to the interrogatories, are you aware of the fact that your institution noted "yes" or "no" with regard to the question of competency?

JUDGE GIBBONS: I think you have to show that to the Doctor.

MR. FERLEGER: Certainly.

JUDGE GIBBONS: In the second place, I think his objection to your question is well taken.

Do you mean competency in the legal sense or in some other sense?

Q. Dr. Tashjian, by "competency," I mean competency to object, whether that juvenile had the capacity to voice an objection and know that that person was objecting to being in the institution.

A. Okay, I am aware—competency in medical or psychiatric sense, that the person's disturbance was not such so that there was extreme confusion or extreme disorientation of thought. In that regard, I would say that they were competent.

(179) Q. How many were competent; what proportion?

A. Just scanning over the list, I would say the majority were.

Q. Dr. Tashjian, adults also object to being in mental hospitals; isn't that correct?

A. Yes.

Q. And, a certain proportion of those adults are competent in the sense we have been using it and another proportion are not competent to object; is that right?

And, Dr. Tashjian—

JUDGE GIBBONS: Just a moment. When you nod your head, the court reporter won't pick up that. He can't see you.

Please respond audibly.

A. Could you start again, so I will know what I am—

Q. Dr. Tashjian, you just nodded your head affirmatively to the question of whether or not some proportion of adults who object are competent and some proportion are incompetent.

A. Yes, from a medical and psychiatric standpoint.

Q. When adults object to involuntary commitment, you understand the law, do you not, the law in Pennsylvania is that they are entitled to a commitment hearing under Section 406; is that right?

A. Yes.

(180) Q. Dr. Tashjian, is it not possible that—

MR. FERLEGER: Strike that.

Q. Dr. Tashjian, you testified that participation in Court hearings weakens an already weakened family situation and that in those family situations—this is with regard to juveniles—there is already verbal violence or physical violence.

Now, I take it that your testimony is that in many of these cases, we don't have a typical, normal, stable family; is that right?

MR. ROTH: Objection, your Honor.

I don't believe that Dr. Tashjian has testified that a hearing weakens an already weakened family situation.

MR. FERLEGER: I have notes of three separate people and I think the record will indicate what his testimony is.

JUDGE GIBBONS: I recollect that he did so testify.

JUDGE BRODERICK: It is my recollection. He may not have testified in those exact words but that is the impression I got.

Let's ask him if he so testified.

THE WITNESS: My recollection is that I did testify that way.

(181) JUDGE BRODERICK: Very well.

Q. You will agree that these situations, these families who were in this turmoil, who seek to have a child admitted to the hospital, you would agree these are not

the normal, stable, healthy families from a psychiatrist's point of view?

A. I would have to qualify that in the sense that the impression can get around that families of disturbed adolescents are monstrous in their deviation from the norm.

I would qualify it by saying that families can have any one of us as parents, that family structure can be weakened by crises, can be weakened by family crises, can be weakened by crises among one or more of the family's members in the family during this time. I don't want the Court to have the impression that families of disturbed adolescents are beyond the pale. If that distinction is clear, that then I would say, yes, that families of disturbed adolescents are often themselves disturbed.

Q. Dr. Tashjian, I want to show you a piece of paper marked plaintiffs' Exhibit 8.

MR. FERLEGER: I have three copies for the Court.

JUDGE BRODERICK: All right.

(182) JUDGE GIBBONS: Plaintiffs' Exhibit 8 for identification?

MR. FERLEGER: Yes, your Honor.

Q. Do the photographs in plaintiffs' Exhibit 8 for identification accurately reflect facilities at your Institute of Pennsylvania Hospital?

A. Yes, they do.

Q. Now, Dr. Tashjian—

A. Tashjian.

Q. Excuse me.

In plaintiffs' Exhibit 8, you notice a list of activities that are available at the Institute.

Would you read that list to us and indicate whether that list is accurate?

MR. ROTH: Objection, your Honor.

I find this questioning is irrelevant.

MR. FERLEGER: I am willing to explain, your Honor, that the purpose—

JUDGE GIBBONS: We know your purpose. You are making the point that the facilities at the Institute are not typical.

MR. FERLEGER: The further point I wish to make, your Honor, is with reference to Dr. Tashjian's testimony that children once they get there don't want to leave; that the reason may be that because the situation (183) is so much more attractive and so much more playful than their own homes—

JUDGE GIBBONS: I don't think you need to pursue this any further.

MR. FERLEGER: Okay.

JUDGE GIBBONS: I have made the point that this private institution is more luxurious than state institutions.

MR. FERLEGER: No further question, Doctor.

JUDGE GIBBONS: Mr. Roth?

MR. ROTH: Just a few questions, please.

Redirect Examination

BY MR. ROTH:

Q. I believe Mr. Ferleger indicated on cross-examination that he sought you as a witness; is that correct?

A. Yes, it is.

Q. Why did you not appear as Mr. Ferleger's witness?

A. Well, I weighed very carefully both sides of the case at hand and decided that my own philosophy, my own professional beliefs lay more on your side than on his side.

MR. ROTH: No further questions, your Honor.

JUDGE GIBBONS: Doctor, is it fair to say that respectable psychiatric opinion exists which would (184) differ from your own as to the issues in this case?

THE WITNESS: Yes. Yes, it is, sir.

JUDGE GIBBONS: From the medical or psychiatric point of view, rather than from a due process point of view, is there any medical or psychiatric reason for distinguishing between adolescents and young adults for purposes of a precommitment hearing?

THE WITNESS: Are you defining an age point, sir, in the distinction?

JUDGE GIBBONS: Suppose you define an age point. I think the law defines the age point as 18.

THE WITNESS: Well, if we say adolescents are 13 to 18 and young adults from 18 up to 25, yes, I think there are medical and psychiatric reasons for making such a differentiation along the lines which

I have sketchily presented Monday, that it's presumed in general—and certainly there are exceptions in both sides of 18—that a young person by the time he would have reached his 18th birthday, will have navigated the major issues of his developing into an autonomous person and developing a personal sense of identity which is separate and distinct from that of his family.

It is presumed that he will in a psychological sense have reached maturity and be able to make judgments in his own regard.

(185) JUDGE GIBBONS: I suppose you would testify that for the under 13's, it is a fortiori case that they have not reached that state of development?

THE WITNESS: I don't understand the term, sir.

JUDGE GIBBONS: Let me ask it this way.

Would you make the same distinction between young adults and children under 13?

THE WITNESS: Yes, I would, because the child under 13 has much less developed psychologically than the adolescent.

JUDGE GIBBONS: Thank you, Doctor.

MR. FERLEGER: If it please the Court, for the purpose of the photographs Dr. Tashjian has identified, I move the admission of plaintiffs' Exhibit 8.

JUDGE GIBBONS: For what they are worth, it will be admitted in evidence.

(Whereupon, the brochure referred to above, was marked plaintiffs' Exhibit 8 in evidence as of this date.)

MR. ROTH: Dr. Miller.

DEREK HARRY MILLER, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Derek Harry Miller.

JUDGE GIBBONS: Mr. Roth, would you please (186) keep your voice up today. We had a little difficulty hearing you on Monday.

MR. ROTH: Yes, your Honor.

Direct Examination

BY MR. ROTH:

Q. What is your profession, please?

A. I am a physician and psychiatrist.

Q. Are you licensed to practice medicine and psychiatry?

A. Yes.

Q. Where are you licensed?

A. I am licensed in Michigan. I am licensed in parts of Canada. I am licensed in Great Britain and Northern Ireland and various dominions.

Q. What medical schools are you a graduate of?

A. Leeds, England.

Q. Where did you intern?

A. I interned at Leeds University and another internship in Canada.

Q. Where did you perform your residency?

A. In Canada and a residency in the Menninger Foundation, Topeka, Kansas.

Q. What is your medical specialty?

A. Psychiatry and in particular adolescent psychiatry.

Q. What specialized training have you received in the field of child psychiatry and adolescent psychiatry?

(187) A. When I was a resident in Topeka, we had a special course in child psychiatry. We did not, in those days, have a special course in adolescent psychiatry.

Adolescent psychiatry is a relatively new subdivision of child psychiatry or psychiatry as a whole and I would have to say that my learning in adolescent psychiatry was one which I guess I sort of led the field in with a group of other people and that I and some other psychiatrists, in the 50's, started to work very significantly with adolescents.

There had been some work before 1939, but not very much.

Q. Doctor, are you a diplomat of any Board of Psychiatry?

A. Yes, I am a diplomat in Great Britain in that I am a member of the Royal College of Psychiatrists.

I also have a higher medical qualification in psychiatry. That is to say, in Britain, you graduate in medicine with an M.B.

I have also an M.D. It is like a Doctor of Medical Science in this country. It is sort of one-up on the standard medical degree, if I may put it that way.

Q. Doctor, have you ever taught psychiatry?

A. Yes.

Q. Have you ever taught adolescent psychiatry?

(188) A. Yes, indeed.

Q. Where have you taught adolescent psychiatry?

A. I taught adolescent psychiatry in England at various colleges of the University of Sussex, Oxford, Cambridge and at the Tavistock Clinic which is a private non-profit-making foundation in England which is run by the National Health Service and is unique in the world.

In this country I teach at a number of universities. I teach at a regular basis at the University of Michigan.

Q. What is your current position?

A. What?

Q. Where is your current position and what is it?

A. Currently I am chief of the adolescent service at the University of Michigan in the Department of Psychiatry. I am associate chairman of the Department of Psychiatry.

Q. Have you authored any psychiatric articles or books which have been published.

A. Yes, a great many.

MR. ROTH: At this time, your Honors, I would like to introduce into evidence Dr. Miller's Curriculum Vitae, which I have marked as defendant's Exhibit 11.

JUDGE GIBBONS: Would you show it to (189) Mr. Ferleger?

MR. ROTH: Yes.

JUDGE GIBBONS: It will be admitted.

(Whereupon, the Curriculum Vitae of Dr. Miller was received in evidence and marked defendants' Exhibit 11 as of this date.)

JUDGE GIBBONS: I hear no objection; is that correct?

MR. FERLEGER: That's correct.

Continued Direct Examination

BY MR. ROTH:

Dr. Miller, how long have you been practicing child and adolescent psychiatry?

A. Since about 1955.

Q. Does your practice include family psychiatry?

A. I don't believe you can treat adolescents without also treating families.

Q. Doctor, throughout this hearing, the terms "child," "infant," "youth," "adolescent," and "juvenile" have been used interchangeably.

Would you please tell us when these terms come into being in connection with human development?

A. Yes, broadly, many of these terms as you know, as is always the case in the English language, are used multiply.

One looks at infants as human beings up (190) until the age two. The word "child" is used, interestingly, sometimes for people up to the age of about 18. Although I think from a medical point of view it probably makes more sense to talk about a child as being a human being up until the age of puberty. "Adolescence" is a stage of development and within that age which is crudely considered to cover the teenage years, there are at least three developmental periods which are sharply defined.

There is a period which lasts about three years in which we are responding to the physical changes of puberty. If you are going to put age norms on, this period ends

at about 14, 15. At about the age of 14, 15, in Western society, generally human beings begin to get interested in a fairly significant way in things that go on outside the family. Generally, the great flush of growth is over.

There is another stage of human development which is middle adolescence, a period in which we are learning to get a sense of ourselves and that lasts about three years and during this period of human development, we are beginning, as it were, to ease ourselves away from our families, although, interestingly, we get very conformist to family norms.

The 15, 16, 17 year old, roughly in this period, is not rebellious at all. They are really very (191) conformist and the last phase of adolescence is one of the periods which is not related to physical growth, and that is a peculiar development associated with our society in which we give people an interesting moratorium. We say, "You must train for certain adult roles in society, but while you are training for these roles in some way, we insist on treating you as if you were not yet adult."

For example, we do this with money; we do this with responsibility about marriage, and so on. So you get a rather prolonged period called "late adolescence," in which people learn to cope with the identity they have already got. Within this period there is a fluctuating relationship to families. That is, through the pubertal period, I would say that in terms of human development, you'd have to say that the family-peer relationships and extra parental-adult relationships are all extremely significant and the family needs to be reinforced in its values for the child by what adults and social networks who are not in the family say about the family, if I make the point.

After the age of 15, a healthy—15 is arbitrary because it may be 17 in some people—after the age of 15, the family as it were is a very necessary back cloth against which development will take place. Having had your healthy family hopefully, about the time (192) you are 15 or 16, you are ready to launch into society somewhat, but you still need to check back, if I can put it this way, with your family.

Now, with children or adolescents who are psychologically disturbed, the family relationships clearly are different. Insofar as adulthood is concerned, there have been interesting definitions of it. One definition is, which I think is nice, by the time you are an adult you are able to predict the likelihood of your prebehavior insofar as it will affect your future possibilities. Or, by the time you are adult, you are able to tolerate being frustrated without necessarily inflicting pain on other human beings. You are adult when you are able to hold your worries and hold your anxieties and not make other people suffer, because of your psychological pain.

Q. Are adults and adolescents psychologically the same?

A. No, they are psychologically quite different.

Perhaps a good demonstration of this would be the issue of the relationship of human beings to time. For example, an adult, and I am talking about a healthy adult, generally has a fair concept of the future. An adolescent is still rather present oriented.

Now there are different developmental rates in men and women. Women reach adulthood chronologically a year or two before men. So, for example, you constantly (193) get into trouble on campuses when young couples

live together as they currently do in that the women often, they have a great sense of the future and they say and feel, if you really loved me, you would want to live with me forever. The young man of 18, 19, in this late adolescence phase still doesn't have a great sense of the future and they are very much wanting things here and now and get anxious, but people start talking about what you do now will affect you or should go on for a very long time. There are many examples.

Q. You have talked in terms of the normal adolescent and adult.

How would that be viewed in terms of the abnormal or the disturbed, if you will, adolescent and adult?

A. There is a very important point about disturbance, that is never ubiquitous in a personality. We have parts of our personality which may be turbulent and cause pain. We may on the other hand have very many healthy parts. It is conceivable, although I trust not, somebody in this courtroom somewhere in their heads can be quite crazy, but there would be no way to know this. It would be that they are showing us the healthy side of themselves.

What we would have to do and this is the grossest generalization, the more adult we are the more (194) we have a healthy functioning personality in terms of being able to be realistic and sensitive, imaginative—not to inflict pain and so on.

If I might, one of the issues which came in an earlier question is relevant to this. The need of adolescents to say "no" to hospitalization is part of being fundamentally enough healthy. An adolescent is striving to be healthy even if they are disturbed, so there are some parts of the personality which are quite healthy and they are struggling

to be independent, to be separate, to be all these sort of things.

So when somebody says to them, "Go into a hospital," they must say, "No," if they have any health at all, because if they don't say, "No," it is like abandoning the ship and it would be like agreeing that I am only a lost, weak, pitiful human being and if you have got any health at all, you are not going to do that.

Q. What is the role made of, of the family in connection with the development of the child in adolescence?

A. The question is frightening in how big it is.

I would say broadly speaking this:

The family needs to provide that sort of loving care and consistency which we require in order to grow. Very specifically, insofar as the development of the sense of ourselves is concerned, our parents, the way (195) they react to each other, the way they react to us, are the models on which we build our personalities. That is to say, we get a perception of our father and mother and both consciously and not consciously, we say, "I would like to be like that." And up until we reach puberty, boys and girls, as you well know, are quite happy often to say, "Yes, I would like to be like my father." Once we reach puberty, when we are trying to separate ourselves which is the process that really begins seriously at puberty and is a very complicated one, particularly boys, go through an elaborate period in which they say, "No. I don't want to be like my father at all. He is square; he is dull."

While they are going through that phase, they are busy looking for adults who strangely they see as being like their father. So they say, "I don't want to be like

my father;" but on the other hand they will find some school teacher hopefully, some minister who they like very much and they will say, "I would like to be like him," and they don't often realize that man in many ways is perceived by them as being similar to their father.

There is a complicated process of modeling in human development which starts with your family relationships and then moves out from your family relationships and what is very important for children is that the models (196) be dissonant. If they are, then the adolescents get very confused. If for example, as can happen, if I might use an example from Britain, if a lower socio-economic class boy or girl gets a scholarship and goes to an English public school which you know is an English private school, the models that they get in the English private school, which is a boarding school, are so different from the models that they have from their parents, that they then get into real confusion about who they are and what they are, particularly if the school staff doesn't support the parents in the way they behave.

Then, the youngsters are really thrown into a real confusion as to who shall I listen to.

Q. Doctor, let's assume the parent brings his child to you. Now, what procedures do you utilize in determining whether or not that prospective patient requires hospitalization?

A. There are really two broad things one can look at, there is the acute emergency which I think is pretty obvious, in which if a child appears—now I am using the word "child" loosely; I am talking about somebody up to the age of 18. If a child appears in any acute crisis which

means that they are being dangerous to themselves or dangerous to other people, then there is no argument about it, we admit them if we have a bed.

(197) We have a policy in our hospital of open admissions and if we have a space we will admit someone. So if it is an acute emergency that presents to our emergency room, we will admit the person. I can go into greater detail because sometimes people come in having made suicidal attempts and they will say they don't need to be here. So, merely being in acute danger to oneself and acutely dangerous to others does not stop an adolescent from saying he wants to be out.

General routine is something like this. We get children referred to us by parents directly. Sometimes by the juvenile court, sometimes by parents via some pressure from the school system, pediatrician or another psychiatrist. Before we will admit, we try to assess and then often these youngsters come with a recommendation for admission and on the day of admission, we will of course try to assess whether the admission seems one, indicated, and two, whether we think that the request is being made to us and that we are the place to be helpful, because sometimes, people will ask for us to take people in and we know we cannot be helpful and then, we will not admit. By the way, although we are a state facility, we differ slightly from the other state facilities in Michigan, in that we can say, "No." This is because we are a teaching hospital, as well. But in a general (198) way, we try to do this:

We try to say to ourselves, "Would this human being be more help-able in our hospital or out of it?" That is one question we ask ourselves.

The other question we ask ourselves is, "Would he be completely unhelp-able if he were out of the hospital altogether? "

Now, that might sound an odd thing to say, but sometimes, we have to admit youngsters to our hospital because they come from the Upper Penninsula, and everybody who knows Michigan knows that is a very long way off and it is too far to travel, so sometimes we get youngsters brought to us and we will admit them for assessment because there is nowhere else for them to go and this puts a particular responsibility on us, I believe and always of course, those boys and girls say, as one would expect, "I don't really want to stay. Let me go home." We will admit boys and girls sometimes under conditions which would certainly not fit the adult commitment laws in Michigan. For example, if we see a boy or girl and if I may use this clinical example, who has been brought to see us, because they are failing in high school and we discover that their high school day consists of moving into the parking lot at a quarter to eight in the morning with some peer and a joint, which is a stick of (199) marijuana, and smoking that and they go on smoking in the high school throughout the day, and this I regret is not as unusual as it ought to be, eventually, you get youngsters who are thoroughly dependent psychologically on marijuana, for example. These boys and girls are not help-able as outpatients, because if I may use the vernacular, they are stoned. If I may be technical, they are intoxicated all the time and you can't relate to these boys and girls while they are intoxicated, so you have to admit them.

As they dry out, you can also begin to get to know them. This is not a cause for commitment of adults, it is

a particular one with adolescents, so we would admit a boy or girl like that.

We would admit a girl to our hospital for example, who was being highly promiscuous, although her other difficulties might not be so catastrophic.

Suppose you have a 14 year old who is being inordinately promiscuous, and in her need to be mothered and cuddled is moving rapidly from boy to boy, frankly collecting cuddling with intercourse the price she pays for it, that child is not help-able as an out-patient, because out-patient treatment always presupposes that the youngster will be able to make a meaningful emotional relationship with whoever tries to treat them and it (200) always presupposes that they will in some way contain their troubles and anxieties to deal with them with the therapist who may be a doctor or social worker or what-have-you and if adolescents are able to go on hurting themselves all the time in this sort of way, we will tend to say, "Admit them," because there is no other way in which we can protect their development and I think the issue with adolescents is different from the issue with adults, because adolescents need treatment sometimes in hospitals to protect their developmental aspect.

Adults, it seems to me, may need to be in a hospital, but generally society adopts the attitude with adults, "We will require you to be in a hospital if we think you are doing certain sorts of things that worry us," but with adolescents, it is an issue of need which is a great deal more complicated.

Q. Doctor, are you aware of the Sections 402 and 403 of the Pennsylvania Mental Health Act?

A. I might get a little muddled about them, but generally I am aware of them.

Q. Are you aware of the additional safeguards for juveniles?

A. Yes.

Q. Could you please tell us, professionally, of what you think of that two-step process?

(201) A. I think it is fine. I have no problems with the two-step process. If I were the receiving psychiatrist, by the way, I would be presenting myself to the child more in terms of trying to make a relationship with them; this is what I want the youngster to feel, that I was trying to make a relationship with them; that I was trying to show them the sort of facilities we have got, which hopefully might be helpful to them in our hospital, where we are, and I think that is as well-staffed as the Pennsylvania Institute, nearly, but physical facilities are awful and really they turn you off in this reception process.

I explain to the youngsters, among other things, what sort of physical surroundings we have and at the same time I would be doing this, I would be assessing whether I thought they really needed to be in a hospital, under some of the terms I have defined.

Parallel to my seeing the youngsters, we always have a professional person see the parents, because there is a funny conflict of interests between adolescents and their parents. Sometimes it isn't helpful if the person who sees the youngster also sees the parents.

We have one of our professional colleagues in our hospital, the day they come in, and by the way, this is a legal obligation in Michigan, they have to be (202) physically examined and so we would do all that and so pretty

much they would be spending a number of hours in the hospital while we are assessing them.

Now, actually, for convenience sake, what happens is, that we start to hotel them on our ward while we are doing this, because they have to have lunch somewhere in all these sort of things. We won't ruthlessly send somebody into town. So the hotelling such as it was, is still going on. It is not limited in our hospital.

Q. Do you feel that psychiatrists and parents operate in a conspiracy to institutionalize or hospitalize their child? Are you aware of any occurrences of that?

A. Yes, I am aware of occurrences because when I became a resident in psychiatry, one of the first things I did working in a state hospital was to happen to be in a ward full of chronic patients and I found an old lady of 45, and she was old before her time, who had been admitted to that hospital when she was 19 for no reason I can establish. She seemed to have been admitted because she had a temper tantrum. I have never in current practice ever come across this.

With the shortage of facilities for adolescents it seems to me inconceivable this could happen, because everybody treating adolescents is in a situation of turning youngsters away.

(203) To my knowledge and I don't know about this state, but getting an adolescent hospitalized in Michigan is an horrendous difficult task because there aren't enough spaces.

Q. Doctor, it has been implied that children are admitted to institutions for the wrong reasons and to protect them a judicial hearing should occur prior to admission.

How would you feel about having a judicial hearing prior to admission?

A. Let me make a point.

I am not against the law and I strongly feel the law should protect the rights of children.

I personally see it as a question of timing. It seems to me the problem is something like this. If a child is going—suppose a child is going into a hospital and on the way he says, "No, I don't want to." That is what one would expect the child to say. That, as I would see it, is the youngster's attempt to say, "I have some autonomy. I have some independence." For the youngster to be sat on with due respect to the Court, by the law and told with the whole majesty of the law, "You must go into the hospital," I fear would be terribly crushing.

That the paradox of the situation is as I would see it, we want to protect the child's right to (204) say, "I don't want to," because that represents health. We don't want to sit on the child's right to say, "I don't want to," because that crushes them and the worst situation you can be in in trying to help an adolescent is to have a passive youngster who won't struggle, because they have given up and, quite frankly, I would be very anxious if the law interceded at that point, because you see, the way we protect a child is this:

Suppose we have a boy or girl in our unit who says, "I want out." Now, that boy or girl has the right now in Michigan to go and get a lawyer which he gets, to go before the Court, which he does. Naturally, he goes before our Juvenile Court and we have in fact—it has to be done under our new Act within seven days.

Now, if the boy or girl has got a good relationship with us, which hopefully he has, and I am using "he" for either, we can and do protect him psychologically while he is going through the process. We have a good working relationship with our Juvenile Court judge who does not sit on the youngster if he says , "No."

We work with the families and help them understand that if, as it usually happens, and it usually does by the way, because we don't keep children who we didn't ought to keep. If as usually happens, the judge says to the youngster, the judge says, "You must stay," (205) we have to explain this to the parents as well. We have never had a child yet, and this may be due to I don't know, perhaps our luck or I like to think our skill, we have not had a situation yet in our hospital in which the judge has removed a child who we say ought to be there. But we don't say a child ought to be with us, lightly. I don't know anybody who does, actually.

Q. What kind of effect would a prior judicial hearing, if you will, have upon the family structure?

A. Well, you know, that's an enormous blanket question, but I tend to think it would be hurtful to family structure in this way. To begin with, assessing a family and assessing a child is quite a complicated business. This is rather a roundabout way of answering the question, but I think it is necessary.

When we admit the youngster for examination, we say to the parents and youngster that the admission in the first place is for not more than four to six weeks, and during that period of time, we would expect to know whether we thought we could be helpful ourselves and if we didn't think we could be helpful ourselves, then, we would suggest some other way in which help was necessary.

Sometimes, you don't keep a youngster four to six weeks because it becomes clear that the crisis rather than the emergency, if I may put it in this way, (206) can be resolved in less period than that. I don't know how to assess almost sight unseen whether the intervention of a Court in sort of stage 1 (A) would be hurtful. I suspect it would and to demonstrate how difficult this would be, I will give you the following example.

In our clinic, we will not automatically have the doctor see the child and the parents together, because we think we need to assess whether that would be a helpful maneuver for the child and the parents.

In other words, somebody will see the parents and somebody will see the child and then we will decide, is it helpful.

Now, I don't know, sight unseen, how you can possibly know whether it will be helpful to the child to be seen in this way, because I think the assessment is inordinately difficult anyway. I think the assessment of need which I believe ought to be the criteria for admitting adolescents and children takes an enormous amount of sophistication and takes a great deal of observation and I don't know how a Court could do this.

The other thing is, something like this, one of the problems that adolescents have who are disturbed is their terrible disappointment in people. You know, disturbed adolescents have tried to make relationships with grown-ups and have failed either because of them (207) or the grown-up. If you really want to know a boy or girl and this is common sense, I think, you have got to get them to feel that you are their friend, you are on their side. These sorts of feelings are obvious.

Now, if it is bad enough that the doctor who assessed the boy or girl has done this and disappointed them by, in a sense, abandonning them when they send them on to somebody else, if the child is to be assessed in a Court, it seems to me somebody has got to make relationship with the child to try and make an assessment as to ought they or ought they not.

My concern is that it is a tease for the boy or girl. For example, one of the things that happen in our unit is that young lawyers come to work with the kids who want out and in working with the kids who want out, the kids begin to see the young lawyers as their friends, which is perfectly reasonable and proper and as it should be. The case goes to Court, however, and as far as the young lawyer is concerned, that's it. He is off somewhere else. So even that procedure can be hurtful, so I would be concerned about it being hurtful to the boy or girl. I'd be concerned about it in evaluating the family and although I agree that psychiatrists aren't often seen by children as being helpful, I don't know that the Courts are seen as helpful by children, (208) quite frankly.

Q. Doctor, in connection with that last question, one point I was trying to question you about—

MR. FERLEGER: Objection.

JUDGE GIBBONS: Let him ask the question.

MR. FERLEGER: I was objecting to his explaining what he was trying to question him about. It seems to me it is leading.

MR. ROTH: I will strike that.

Q. How do you value—let me put it this way: How does the child value a family?

A. The child values a family first of all if they value themselves.

Parents who see themselves as good people and as good parents are in fact likely to be valued by their children, which I guess is reassuring. Families, however, also need to be valued by society. It is painful to children, indeed, when society does something to their parents; sometime the parents precipitate it, but then society does something which the child sees as a devaluation of the parent. One of the things society has been careful to do, I think, even though sometimes society has sometimes to punish parents as people in society,. they don't generally devalue the parental role unless they see the parents behaving in a way which society (209) sees as hurtful to the child.

Very specifically, society only interferes in family structure, and I believe this is right, when it sees parents doing something which society says, "You cannot do this because you are hurting your child."

I think likely for that to happen, society, you know, as shown by the Courts, tends to demand very sophisticated proof this is so. In Michigan, the law is that if we see a child who we think the parents are abusing we are obligated to tell protective services and if they think we are justified in being concerned will then go to the Juvenile Court and ask for a guardian ad litem to be appointed. I believe quite rightly, the law is quite sensitive about this.

They don't generally cut into family structure.

Q. What type of interference do you think would occur if the hearing occurred for a juvenile prior to admission where the parent is in conflict with the juvenile or the child?

A. It would seem to me that what would be happening would be that a child's statement which I have tried to point out is inevitable, that "I don't want to," is going to be taken by the Courts, I think, and I am not—I think—I am talking about the parents, as meaning the Courts (210) are going to adjudge their worth as parents.

It seems to me there is very little difference in some ways between my child of 14 saying to me, and perhaps I say this because I am a psychiatrist and I don't think being in treatment is that awful, but if my child of 14 says to me, "I don't want to go to this school," it seems to me my role as a parent is to say, "If I believe that it is the right school, you should go to this school," and frankly, if society then wanted to cut in, assuming it was a good school and recognized by the educational authorities, cut in and allow my child, as it were, to hold my parent-ing up, over that sort of issue, it seems to me we are in a very interesting ball park.

Now, I get the feeling that something similar is in this hearing. It seems to me the parents have to make a judgment about the statement of their dependent children. If they are not capable of making that judgment, that seems to me to be a very sophisticated assessment and as I would see it, this is under the guise of the issue of institutionalization; very real questions are being raised about the value of parenthood and I must take a point that if a parent says, "You must go to a hospital," and hopefully, the psychiatrists who have seen the child are competent and everybody is competent and they tend to be I think in this state as in ours, and the (211) Court said, "No," I believe the Court has a tiger by the tail, because the Court in fact has then said loudly and publicly, "You do not have to listen to your parents."

Now, once you are over the age of 15, parents can no longer—I use that in terms of the end of puberty—parents can't control you by force. You know, frankly, a pubertal 15 year old is likely to be bigger than his father and if you wish to control him, you sure as heck can't do it by force. You can do it hopefully because you are respected by the child. Hopefully, 15, 16, 17 year olds will do what we say, because they respect us.

Now, if our children are told, "You don't have to do what your parents say," then we have put them in the situation, I believe, in this very complicated society, where I would remind you that 42 million people move a year, which means they may have no one else in their lives, but their parents; we have put them in the situation of taking anybody away whose opinion they can value and I think that is a very dangerous thing to do.

Q. Doctor, in Pennsylvania, the hearing is provided subsequent to admission for juveniles age 13 to 18, who object—

A. Yes.

Q. —Do you feel that procedure would be harmful to a juvenile?

(212) A. No, providing, as I would hope, that the institutions and the lawyers work responsibly together.

The implications of that statute is lawyers ought to understand something about psychological illness. Psychiatrists ought to understand something about the law, if I may put it this way. I think it is very important that the child does not, as it were, catch an adversary relationship between the lawyer and the treating people, because they will divide and rule, which is not always helpful to youngsters.

I suppose I shouldn't throw in gratuitous comments, but I guess I have the feeling if the law really takes more responsibility for saying a child must stay in a hospital, then, it seems to me, the law will have to take more responsibility for the quality of caring for patients in hospitals.

And, quite frankly, I'd like to see more responsibility taken by society for the quality of care in most hospitals.

I must make a point. I am not against the law intervening in the quality of treatment. I am not against the law supporting a child that is needing to be in treatment, but what I am against is the sort of timing that is being thought of here which I can see only as enormously destructive and not at all helpful.

(213) There is one other issue. We have to be very careful not to label children. One of the things that made me a little unhappy with your law, if I may say it, is you have something called voluntary commitment. If I understood it right and I may not have, because I am not a lawyer, it means that there are certain situations in which you voluntarily accept the label of being mentally ill; am I right about this?

If that is the case, then I think it is deplorable that children should be labeled. One of the responsibilities I would see the Court as having is when they tell children they need treatment, which they may tell them, they should not stick a label on them, saying, "You are crazy," because one of the problems children have if they are mentally or emotionally upset is they don't know who they are and they are all too willing to adopt the label we give them and so if we label them delinquent, they become that way; and if we label them under-achievers, they become that

way; and if we label them crazy, they become crazy; and the responsibility of a hospital is to provide facilities that don't add to the self-labeling quality.

Q. Doctor, do you feel juveniles should be permitted to release themselves and admit themselves as adults, under 402 and 403?

(214) A. No.

Q. Why not?

A. I have no objection to a juvenile admitting himself, providing that in so doing, they are not getting the institution to act against their parents.

You see, there is a very interesting—you know, disturbed youngsters who are trying to assess the value of their parents, play a sort of fascinating maneuver. They will try in all sorts of ways to get people to agree in action, that their parents are no good. So, if say, a 16 year old who is not an emancipated minor, that is to say, he has contact with his parents, lives with them, presents himself for treatment in our hospital, whether it's in-patient or out-patient, we will see the boy or girl once; we will not see them more than once, because we believe that in so doing, we are implicitly agreeing that their parents are not good people and we are not prepared to agree to this.

So, we will not admit an adolescent who is not an emancipated minor, which a different category, who is not suffering from venereal disease which is a different category in our state and which is not drug indicated and excluding those, we will not admit an adolescent under any circumstance without the agreement of his parents and I might add, because of the peculiar financing of the (215) Department of Psychiatry of the University of Michigan, this is not primarily a money issue, because in our state, if the parents can't pay or if the insurance carriers cannot

or will not, we have a state appropriation that picks up the bill. So, it is not an issue of money.

Q. Doctor, there's been some indication that if a child needs help, that under Pennsylvania law, if it is an emergency, he ought to undergo an emergency commitment.

Now, my question to you is:

What kind of crises do you find juveniles—do you find juveniles are relating to when you first see them; are they emergency crises as being dangerous to self or others?

A. Sometimes, they are crises in a sense. Take a boy we got admitted the other day. He had shot himself somewhere in the thumb, had been admitted to the local hospital, alleging that he had been shot by an intruder. The local surgeon was really quite clever and decided that that sort of thumb shot wound could not have possibly been done by somebody else and he was sent down to our emergency room and he was admitted.

On the spot we got a history of five suicidal attempts from him over the year and he still said he didn't want in. What happened was he said he didn't want in and we say, "Of course, you are to come in."

(216) We have never had ever to drag a child into our hospital. The interesting thing is they say they won't, you bow to the fact that they won't and then they come in as you would expect. That is a typical crisis. Typical crisis which causes trouble or emergency that causes trouble is when adolescents have behaved in a way which is acutely murderous, which is regrettably not unusual and that is troublesome because if an adolescent has been violently assaultive in their behavior and then they frighten

people and they come in with a fear around them which tends to be terribly disrupting to adolescent wards, so that is another sort of case, however we might take it.

We won't take for example, youngsters who have murdered somebody, because we don't have the sort of facility that can protect them or society. I should say youngsters who committed homocide. I think I am being technical. Otherwise, we will take youngsters who have physical illnesses, who abuse their own physical illnesses; diabetics who get out of control, epileptics who won't take their medication. We take youngsters who behave with direction in a way which is destructive to them.

We take youngsters who repeatedly run away from home and put themselves in danger by exposing themselves to who knows what and so on.

(217) Admission is always a crisis, you know, because even if everybody said, "We want you to come in," at that moment in time, it is a painful crisis.

Q. Doctor, you indicated in your answer before, that there was a labeling process, as you understand the law to be?

A. Yes.

Q. I question what effect would a prior hearing have had on a youngster in relationship to a labeling process?

A. Well, I think it would give them a very false sense of their own psychological state in a whole variety of ways. If they are labeled so ill that the law says, "You must go to a hospital," I could only leave this to, I think, the imagination of the Court as to the message this is giving.

Heaven help the child if the law says, "You are solemnly—," I don't suppose it would happen, —"Under Section so and so of this Act you ought to be in the hospital," because that means the youngster gets a strange specialness which will not be helpful.

I think the two things to worry about are false labels and crushing children, and of the two, I don't know which I'd be concerned about most. The thing to worry about insofar as the family is concerned is undercutting their roles as parents.

(218) Q. Doctor, if the hearing were held before admission and the juvenile were present, hearing all the symptoms that may require, if you will, his admission, how do you think that would affect the juvenile—how do you feel it would affect the juvenile?

A. One of the important aspects of growing up is privacy. Everybody in this room who has been an adolescent and we all have, or who have adolescent children of their own, know perfectly well that a very important thing for them is to be emotionally private from their parent sometimes. Adolescents do not tell us everything. One of the things that adolescents have to do when they go into treatment is, to some extent, they have to abandon this privacy. They have to let grown-ups in on their private world which normally they don't do.

Normally they keep a great deal of it to themselves. I believe this is a very special responsibility, quite frankly. I believe we should not over-pressure adolescents to tell us too much, too fast, because that's assaultive.

I believe we should have much respect for that private statement, because that seems to me to be important, too. In those cases in which for example, it has been necessary

when a child wanted to go before the Juvenile Court, if we had wanted to say something that (219) the child has said, which he might not want his parents to know, for example, we ask permission and do sort of approach the Court, tell the judge what the child has said with the child's permission and this may be going to happen. There is a real issue of protecting privacy.

The problem is, you know, that adolescents who are psychologically ill are very easily persecuted and they very easily feel the world is attacking and you have to tread on eggshells not to do things they feel would be attacking. Appearing in Court is a very sophisticated business, I would tend to think, particularly if the child is there.

Q. Doctor, do you feel that the age of 18 is satisfactory in limiting a parent or do you feel that that age should be increased or lowered for the juvenile to be able to admit themselves?

A. I never thought when I was a young man that one day I would be thought of as conservative, reactionary and those sort of words.

One of the most deplorative maneuvers Western society pulled was to move the legal age of adulthood back to 18 from 21. Adolescent-like aging is a time of life of transition and a time of life where you cannot fit where people are psychological to chronological age.

Twenty-one was an excellent age of adulthood, (220) because by then, most people have reached physiological and thereafter psychological maturity. By 18, most people—I won't say most people—a significant number of people are still showing signs of immaturity, because for example, they were late developers into puberty. Some people become pubertal at 11 and a whole series of psy-

chological changes take place. Some people don't become pubertal until 16. Very tall people do not become pubertal until they are 16, very often.

People who arrive at puberty at 16 need three or four years to catch up to themselves, and the legal age limit of 18 causes complications for those adolescents who are late maturers. And, unfortunately, it invited middle adolescents to become choleric. One knows they identify with behavior of older adolescents and older adolescents are now in our state allowed to go into bars and this means to 15 year olds that they ought to go into bars and barmen can't tell the difference, and they can receive a fake identity card.

It is a mess, but it's been done.

Q. Are there hearings given in Michigan prior to admission of a juvenile?

A. Only if the juvenile has broken the law and is going to go to a hospital via the Courts. That is, there are some juveniles who have broken the law and may be sent (221) to us or any other psychiatric hospital by the Juvenile Court when it's been established that they have broken the law and the defendants—it is usually the defendants that request hospitalization, and they can be sent by the Court. They are not committed, usually in a formal sense. The Court merely says, you know, "You ought to go be treated in this hospital," and that's done in the Juvenile Court.

Sometimes adolescents who are waived to the adult courts—I don't know whether this procedure takes place in Pennsylvania, it does in Michigan—a 15, 16 year old can be waived to the adult court, depending on the severity of their crime and they may be ordered to the hospital and

be legally committed to a hospital. Those are about the only adolescents in the state of Michigan who are committed because, our law is different to yours and so commitment as such is very rare there.

Q. What happens if a parent wishes to admit his or her child into your institution, and assuming all prior safeguards are met and the juvenile objects, when is the hearing provided?

A. The point I will make is, almost all of the juveniles object in words prior to being admitted. They don't object in action, and then, what happens is, that usually when they get admitted, they are—initial objection tends (222) to go or they do a very interesting thing. They go on saying, "I don't want to be here," but they go on acting as if they do want to be here, which we expect.

For example, I saw a girl the other day who was 15, who I suppose was the most abusive—colorfully abusive child I have seen in a long time, and she was colorfully abuse in the most amusing language and told me in some 50 minutes how she had no intentions of staying in my blankety-blank-blank hospital, and she would run away and she wanted a lawyer and so forth. We proceeded to get her a lawyer who arrived about three days later. When the lawyer came, she said she didn't want him. She left my office; she went from my office to the hospital school. So all the shouting of, "I don't want to," was verbal and not behavioral and that is common.

Q. But, Doctor, after the child has been in the institution, is there any mechanism in Michigan for providing him or her with a hearing?

A. Oh, yes, the child says, "I don't want to be here." We are then obligated to get the child an attorney

which we proceed to do. We have a number of attorneys floating in and then being told by the children they don't want to see them, which is another maneuver they can pull.

After all, you can disturb the law as well as disturb everybody else. But they get their attorney, (223) the attorney comes and explains their rights to them and so on and so forth.

Q. And, what age does that apply from?

A. Thirteen. The law in Michigan is 13 on up and they must be provided an attorney within seven days and you may exclude Saturday and Sunday, I believe—but they must get the attorney within a seven-day period.

Q. In general, then, you are familiar with there being a hearing afterwards?

A. Oh, yes.

Q. When a juvenile objects after he's been admitted, is there any attempt by the institution to coerce him or to provide punishment, rather than provide him with an attorney?

A. I suppose, I would love to be able to say nobody in our institution is ever punitive because punishment is terribly sterile for adolescents, I would think, unless it's applied by people who they perhaps really know love them and they don't really know we love them so we don't punish.

Punishment does not apply as far as we are concerned. I mean I can't guarantee that there is not some member of our staff who has got in under the wire who behaves as they shouldn't behave.

In a general way, I would think punishment (224) was not an appropriate word in our facility, frankly.

Q. Doctor, one last question; it has been alleged that juveniles are in institutions as mentally ill when their actions may only be defined as juvenile delinquency.

A. Sorry.

Q. It's been stated that juveniles are in institutions, because they are supposedly mentally ill when their actions would only be those of juvenile deliquents. They would be considered delinquents.

Would you please comment upon that?

A. As you know, juvenile delinquency is socially defined. You become one when the law says you are, and whether the law says you are will depend on your social class, the ethnic class.

One of the problems is that, typically, adolescents who are in pain show their pain by inflicting pain. That is to say, typically, an adolescent asks for assistance for himself or herself by behaving in a way which society would perceive as painful, so to some extent in that they arbitrarily inflict pain on others to meet their own needs.

Really, all adolescent illness is antisocial, if I may use that phrase instead of juvenile delinquent. It is almost inconceivable for an adolescent to be psychologically disturbed without hurting someone, (225) either his parents, his teachers or himself, if by no other reason, but making them helpless and useless and this is one of the things that adolescents do.

Adolescents get great gratification unfortunately, particularly when they themselves feel helpless. They get a lot of gratification from stirring up people in their environment and one knows this very well. This is not very helpful to them ultimately in helping them. If he requires

psychological treatment, it is more complicated because sometimes clever juvenile delinquents are so terribly successful. It is very difficult to convince a 15 year old and I saw one the other day, who successfully made $24,000 by stealing IBM machines from a variety of offices and then selling them. It is very difficult to convince him that this is an unsatisfactory way of living.

His attitude was, "Don't tell me that crime doesn't pay; it does." He was not very motivated to have anything done. So, to that extent, successful delinquency complicates treatment.

MR. ROTH: I have no further questions.

JUDGE GIBBONS: We will take a five minute recess.

(Whereupon, a recess was taken.)

JUDGE GIBBONS: Back on the record.

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(226) *Cross-Examination*

BY MR. FERLEGER:

Q. Dr. Miller, from your Curriculum Vitae, I notice last year you published an article called, "The Effects of Social Prejudice on Hospitalized Patients."

Now is it your opinion that social prejudice more adversely affects hospitalized patients as opposed to mental patients on an out-patient basis?

A. The article actually was really not about that at all. It was discussing the Eagleton affair and it was discussing the relationship between the behavior of groups of adolescents on a ward and their knowledge of the Eagleton affair, if I can call it that, and the prejudice actually against being a psychiatric patient.

It wasn't the issue of an in-patient or an out-patient. It was frankly, the issue of being aware of the prejudice.

Q. We can agree that there is a tremendous amount of prejudice in our society in being a psychiatric patient.

A. I would have thought still.

Q. Dr. Miller, you testified with regard to adolescents that the need to say no is a rather healthy need because they desire to be healthy or some part of them wants to be recognized as healthy. The same process occurs in adults, isn't that correct?

(227) A. Yes, but I am not sure it is quite the same.

You see, an adult who says no is presumably saying no, one would hope, only out of the conviction that the reality with which he is being presented is demanding a negation. An adolescent says no because a main motive is to say, "I am myself."

I don't think that's a primary motive with adults. I would hope not.

Q. But it is also a motive even—

A. I would hate to generalize about the adult population. I can conceive that some adults would need to say no, because of some inner psychological reason, but I couldn't possibly generalize about everyone.

Q. But, you would make that generalization about juveniles, though?

A. Oh, yes.

Q. But not about adults?

A. That's right. One is in the area that I work in and the other is an area in which I work less.

Q. Doctor, you testified that for the majesty of the law to sit on a child and say, "You have to go into the hospital," would not be proper.

Now, the current state of the law which does tell the child, "The law requires that you must go in;" isn't that also sitting on the child?

(228) A. The point I'm trying to make, it was depending on how it is done and when it is done and who the child is perceiving as helpful and supportive and so on. It is a multi-determined situation.

Q. It's possible then that there could be a situatior if the Court was as creative as it might be where we might develope a procedure where the child would see the process as a friendly one rather than as a surrogate one?

A. Social change is always terribly difficult and I would hate to express an opinion about that sort of social change.

Q. Doctor, you testified that the age of 18 is acceptable, though you regret that we have retreated from the age of 21.

Now there is pending in the Pennsylvania legislature and I am sure you have not seen it but it is an attachment to Mr. Roth's documents that will allow children 14 and up to admit themselves into mental hospitals.

Would you agree with that bill and support that proposal?

A. I find it extraordinary. I haven't seen the bill and I find it generally extraordinary that a society which prided itself in its increasing civilization by protecting its children more and more with things like child labor laws and the like should in these subtle and (229) insidious ways as I see it, turn the clock back. It's very remarkable.

Q. Now, you may be aware—are you familiar with Dr. Masterson's book, Teaching and Learning Adolescent Psychiatry?

A. You put me in a terrible spot. I have looked at it, yes.

Q. In his preface he notes with approval that in Georgia, the law now allows teenagers to get psychotherapy on their own volition.

Would you support the law and allow teenagers, however you define them, to get treatment on their own?

A. In the last part of your sentence is the issue.

The issue is, what do you mean by teenagers? I would make the point that if an adolescent is emancipated from his parents, then I would feel quite strongly he ought to be able to seek psychotherapy on his own.

Q. Unemancipated teenagers should not be allowed?

A. I think you are getting into very interesting technical areas.

I might or might not disagree with Mr. Masterson. It is my belief that we as doctors should not behave in a way that the child—that a child could see as taking his parents' role.

(230) The problem is that if a boy or girl comes for therapy and says, "I need therapy. I want it, but my beastly parents . . ." et cetera, et cetera et cetera, when one knows the child is seeing the parent as beastly but they may not be at all.

One of the great difficulties in this whole area is that if you do see a youngster without the parents' knowledge,

it seems to me, professionally, this does not go well. In Britain, there is no problem of patient—

Q. Excuse me, I was not talking about without the parents' knowledge.

The question is whether or not the parent consents; not to do it secretly, but to do it simply with the child applying.

A. I can see no problem if the parent of a child of 17, 18, or 19, says no, because by 17, 18, or 19, depending on the psychology of the child, the psychology of the parent, it might make sense to go along with that.

My general experience is it does not. I generally feel that parents when they say no, are themselves saying, "Please explain to me what this is all about," and so on and so forth.

Q. Doctor, you testified that a full and open hearing with a child listening to possibly private things, could be detrimental.

(231) Do you think that that problem could be cured simply by having some of the testimony heard in the presence of the child's lawyer, but with the child absent?

A. I suppose this is the area of the issue of the child's confidentiality and the keeping of the confidences and so on and this is terribly complicated.

If a boy or girl has only chosen to tell his lawyer certain things, then, it seems to me that the lawyer is entitled or should assume he's been told it all.

Now, I have had a case and situation which I know perfectly well the lawyer has not been told it all. I would not see it as my responsibility to tell the child's lawyer what all of it is.

Q. Can you answer my question which is whether or not a Court could adopt a procedure which might make it less traumatic or not traumatic for there to be a hearing by taking some of the testimony—

A. We seem to be back in the social change area.

Theoretically a Court can do all sorts of things.

Q. You don't feel you are qualified in that social change area?

A. I have done quite a lot of work in social change. I know how terribly complicated it is.

Q. Doctor, you are aware, I'm sure, that in the juvenile (232) delinquency area, some of the reasons they are categorized as that is because they are incorrigible and do not obey parents and they can petition the Juvenile Courts to get the children to obey and if the parents bring such a petition and the Court says the child was not being disobedient to the extent the Court would get involved, isn't that sort of a situation where the Court would be infringing upon the parents' right to demand obedience from children?

A. Yes, and most responsible Juvenile Courts feel this way strongly and if they get into this situation, one of the things they surely do and good Juvenile Courts have attached to them, many social workers, professional assistants and so on, and I think they commonly see this petition—perhaps "commonly" is wrong; I don't know enough—but it is not within my experience for a good juvenile judge if this petition is before him to see this as the representation of a family crisis. Although he may dismiss the petition he may instruct his Court social workers to try and help resolve the family crisis.

Q. I asked if that could not be perceived as the rejection of their proper parenting role—the parents?

A. I am less anxious about the parents' feeling that their role is being rejected than their child seeing that their role is being institutionally devalued. I think they are quite different.

(233) Q. If the Court said to the parent, no, petition denied, couldn't that result in the child's feeling that the parents—you know, "You parents blew it."?

A. I think that is an inevitable conclusion one would reach and I think it would be a sad situation if, frankly, applying the law in an arbitrary fashion, a judge was to say this, not knowing what family disruption he may cause thereafter.

Q. Doctor, you would not want to end the practice of holding hearings for accused juvenile delinquents, would you?

A. Most certainly not. I think they have every right to have a proper hearing as to whether they are guilty of the behavior of which they are charged or whether they are not.

Q. That would be true even—

MR. ROTH: I have noticed on a few occasions the Doctor has attempted to continue with an answer and he has been interrupted.

JUDGE GIBBONS: Would you finish your answer.

THE WITNESS: Yes.

Q. That would be true whether or not the juvenile delinquent had an emotional disturbance?

A. Since a large number of crimes that are committed by juveniles of emotional disturbances, I suppose society (234) says that they must be adjudged in the Juvenile Court.

If I inflict pain on society as a youngster to which society takes such exception to label a crime, then it seems to me that there is a price that's asked and society has to adjudge whether or not I committed the crimes and I believe they should do that.

Q. Now, Doctor, I appreciate very much your comments earlier on the question of timing of this due process and protections for children.

I would like to describe for you just very briefly a proposal that Pennsylvania's Association of Retarded Citizens has made to the Court and see if you would feel that this sort of timing is—

JUDGE GIBBONS: You mean this Court?

MR. FERLEGER: Before this Court.

JUDGE GIBBONS: Would you refer to an Exhibit number so someone in the future would be able to know what you are talking about?

MR. FERLEGER: For the record, I am referring to a document which was docketed this past Friday. I don't have the docket entry number which is titled, "Brief of Amicus Curiae Pennsylvania Association for Retarded Citizens, Incorporated, and National Center for Law and the Handicapped"—

JUDGE GIBBONS: Show the witness that (235) document.

MR. ROTH: Your Honor, I would have to object. I do not have a copy of that. Where are you referring to?

JUDGE GIBBONS: What page is that?

MR. FERLEGER: Page 39 and the next page or two.

Q. It would be just as satisfactory to me, Dr. Miller, if it pleases the Court, that I can just summarize a procedure and see what you think of it.

A. May I mark this copy?

Q. Certainly.

MR. ROTH: Your Honor, I am going to have to object. It seems to me that the issue at hand is whether or not a hearing should be provided prior to the admission of a juvenile and not whether or not this Court should have the function of determining what type of procedure ought to occur, other than recommending a due process hearing or not.

JUDGE GIBBONS: Overruled.

A. I must say, I am most unhappy really about expressing off-the-cuff opinions about something that people really thought out and I am rather distressed to say, "Yes, it looks fine," or "No, it does not look fine."

Q. I am not asking you to do that.

(236) Let me ask you a question, Dr. Miller, with regard to that. That procedure, to paraphrase it, involves having the juvenile and the parent get together with a review board at an institution to discuss the proposed plan of children. The juvenile will be very assured that this is a very serious thing and there will be an atttempt to work out something that is acceptable to the juvenile, his or her attorney and the parents, for a voluntary commitment to be signed by the parents.

This will be an informal hearing, not before the Court, you know, with relatively littlc formality. Only

if nothing can be worked out in that administrative hearing, will there be a judicial hearing, if the child or the parents objects.

Do you think that such a procedure which avoids, it seems to me, some of your objections about the Court being involved, would be acceptable to you?

A. Do I understand that what would happen is the child would have been admitted to the hospital and he would have been in the hospital for some time and the hospital staff would have worked out a treatment program which seemed to be appropriate for the child's needs—

Q. No, it would be prior to hospitalization.

A. That's impossible.

You cannot work out a program for a child (237) like this prior to hospitalization. It's a naive idea.

We have a hospital school. Children come to us and I guess I have many negative feelings about the American high school system. Children come to us from high schools with statements, for example, that they have failed completely in everything and the note that we will get from the school will tell us absolutely nothing about that child's attention span, ability to be cognizant, ability to achieve imaginatively, et cetera.

Until we placed that child in our school setting and assessed that child's ability, we are completely unable to say what sort of school program the child should have.

Q. If you have a procedure that Pennsylvania law allows for out-patient evaluation, which could take a few weeks, would that improve your opinion as to the feasibility of this proposal?

A. You see, if the circumstance were such that the child was willing to come, that the family situation was not one of maximum—was not stressful, than in a general way, I would imagine that you would prefer out-patient treatment anyway.

You only send a child into a hospital when the stress in the family or the child's inability to contain anxiety is so little that in fact the child won't (238) come, or for example, the child physically cannot because of distances. So, if out-patient assessment is possible, it may well be that in-patient treatment is not necessary. It may be, but it may not be, but I thought we were talking about youngsters who needed to be in hospitals.

This is my unhappiness about this because I have a feeling we can spend a long time at looking at what you mean.

Q. Just to be clear, we are talking about assessing the need and figuring out whether or not someone needs to be hospitalized.

The question is how is it determined whether or not he has to be hospitalized?

A. This is talking about agreeing to a treatment plan, isn't it?

Q. Yes.

A. And I, by the way, very much believe that parents should be told of the treatment plan, should be involved in it, should understand it, et cetera.

Q. Do you feel at the time of admission, there ought to be or after an evaluation, of course, that there ought to be a work-up of the proposed treatment?

A. Treatment plan is not a rigid thing. Treatment plans vary very much on the state of the child. I guess I

am unhappy about answering your question, because it (239) seems to me that there are so many ifs and buts around it, that I feel I am not saying anything constructive.

Q. Let's get on to something else, then, Dr. Miller.

You, in your book, Growth to Freedom, the Psychosocial Treatment of Delinquent Youth, you discussed a residential program for offenders or delinquent youths, and in working out this adventurous program of a non-institutional care for delinquents, you discussed the negative effects of institutionalization.

A. Yes, I have great concern about the negative effects of institutionalization.

Q. You spoke about correctional systems and the systems in England, et cetera; is that right?

A. That's right.

Q. You stated, "People who have been institutionalized, that that process tends to produce what has been called an emotional deficiency disease;" is that right?

A. That's right. By the way, I must explain something.

Institutionalization in that sense is being used technically. That is to say, in theory, you become institutionalized, I believe in social terms, if you are merely placing someone in an institution. In a sense you are institutionalizing them. That's not the sense in which this is being used.

Q. I understand. You mean by "institutionalization," (240) the total institution that Goverman described, or the kinds of places that we call mental hospitals and juvenile institutions; is that right?

A. In general.

Q. Without talking about institutions like this Court; is that right?

A. No, I think not.

It may institutionalize us eventually, but—

MR. FERLEGER: No further questions, your Honors.

JUDGE BRODERICK: I would just like to ask one question, Doctor.

I wonder if you had an opinion as to whether some type of a preadmission hearing would tend to encourage or discourage parents from seeking psychiatric help for their children? Had you thought about that?

THE WITNESS: I had not honestly thought about it very much, your Honor. It is terribly hard to say.

In general, parents are understandably, most parents are very reluctant to seek hospitalization for their children—psychiatric hospitalization. They do almost anything to avoid it.

I think in lower socio-economic classes (241) parents do tend to have a conviction of the Court as being hostile, because I think that can be in the culture. I think they find it harder. I think middle class parents who may know a judge who lives next door and have a quite different acquaintanceship with the law, it may not make any difference.

I tend to think the poor and ethnic minorities who are often very paranoid about the law might find it hard.

JUDGE BRODERICK: I have no further questions.

JUDGE GIBBONS: Thank you, Doctor.

(Witness leaves the stand.)

JUDGE GIBBONS: Call your next witness, please.

MR. ROTH: I'd like to call Dr. James Masterson, please.

JAMES F. MASTERSON, sworn.

THE CLERK: Would you state your name in full?

THE WITNESS: James F. Masterson.

Direct Examination

BY MR. ROTH:

Q. What is your profession, Doctor?

A. Psychiatrist.

Q. Are you licensed to practice medicine and psychiatry?

A. Yes.

(242) Q. Where are you licensed?

A. New York State.

Q. From what medical school did you graduate?

A. Jefferson Medical College, Philadelphia.

Q. Where did you intern and for what length of time?

A. Philadelphia General Hospital for one year.

Q. Where did you perform your residency?

A. The Payne-Whitney Division of the New York Hospital, Cornell Medical Center, New York.

Q. What is your medical specialty in psychiatry?

A. Adolescents.

Q. What do you feel qualifies you as an expert in that field?

A. The time I interned, my training in adolescent psychiatry which was in about 1956, unlike child psychiatry and adult psychiatry, at that time in the development of this specialty, there were no places to be trained as an adolescent psychiatrist; in that sense I did not have a formal training, but I was taught by the best teachers, the adolescent patients. I started a clinic in 1957, an outpatient clinic and started doing research and over the years I have continued that and have contributed a good deal to the literature and text books.

Q. Are you a diplomat of any Board of Psychiatry?

A. American Board of Psychiatry and Neurology.

(243) Q. Do you currently belong to any professional groups?

A. Well, lots of them.

Q. Have you ever taught psychiatry?

A. I have been teaching it since 1956.

Q. What brand of psychiatry do you teach?

A. Mostly adolescent psychiatry.

Q. Where do you teach it?

A. At the Cornell Medical Center since I finished my residency there in 1956, and since '68, I have been in charge of a program for the treatment of adolescents and the teaching of psychiatric residents adolescent psychiatry.

Q. Have you offered any psychiatric articles or published any books?

A. Yes, both.

Q. Are these articles and books related to adolescent psychiatry?

A. Yes.

MR. ROTH: Your Honors, at this time, I would like to introduce as defendants' Exhibit 12, the Curriculum Vitae of Dr. James Masterson.

MR. FERLEGER: No objection.

JUDGE GIBBONS: It may be admitted.

(Whereupon, the Curriculum Vitae of Dr. Masterson was marked defendants' Exhibit 12, in evidence (244) as of this date.)

Continued Direct Examination

BY MR. ROTH:

Q. Doctor, have you ever been associated with an institution?

A. The medical center in which I work, in the sense of a psychiatric hospital; I have been associated with them since 1952.

Q. What hospital is that?

A. The New York Hospital.

Q. Do you recommend hospitalization of juveniles?

A. Yes.

Q. Do you admit juveniles?

A. Well, as the head of the program, of the inpatient program, I am in charge and pass on all patients who are admitted and all who are rejected for admission. So, I do it all the time.

Q. Doctor, would you please explain to us, when a patient comes to you with his parent, what you look for from the standpoint of the patient, the parent and your own role?

A. When the patient comes, we see him as coming —the adolescent as being the patient and coming to us for an evaluation. Our function is to try to evaluate this problem in the adolescent and come to a decision as to what is the best treatment for him.

In the course of this, we examine the (245) parents and get their reports as to the behavior, examine the adolescent and take whatever other reports are sent in from schools or social agencies and through the process of examination, often will confront and challenge some of the evidence that is brought in by the family and try to come to some decisions as to what is wrong and what has to be done about it.

This may or may not require hospitalization. If we think—Dr. Miller has already indicated some of this—if we think, you know, let's say at the most urgent he is a danger to himself or others, then he will be hospitalized. If he cannot function in the environment, cannot maintain himself in school or manage his relationships with his peers or parents and just cannot function, he will be hospitalized or if perhaps he is suffering from the difficulty of controlling impulses to such an extent that he's gotten himself into all kinds of behavior problems, we will hospitalize him.

In general, hospitalization is probably the last alternative used. First you would think of out-patient treatment and other forms of care and then, if these are not appropriate or do not work, you think of hospitalization.

Q. Doctor, from your experience, do you discover that parents take alternative measures before hospitalizing (246) their children?

A. In general, for the most part, they are very reluctant to hospitalize them for lots of reasons. Part of their reasoning having to do with the interaction between the parents and adolescent.

Whatever function that the adolescent performs in the family system is interrupted when the adolescent goes into the hospital and this creates difficulty for the parents and for this reason, among others, they don't want to hospitalize them and try some other method first.

Q. Do you practice adult psychiatry?

A. I see adults in my private practice.

Q. What are the psychological differences between the normal adult and the normal adolescent?

A. Well, simply stated, the adolescent is in a state of incomplete development and the process of adolescence is one, a process whereby he masters certain tasks, and in the course of that, becomes fully developed and becomes an adult and just to summarize it briefly, the areas in which he does this is, first of all, the area of emancipation, where he emancipates from the family and this really involves two fundamental parameters.

One is, he goes from becoming emotionally dependent on a mother and father to being independent (247) and in the course of this, his values or standards or conscience changes from being more or less a repetition of his mother and father to being an amalgamation of that and other influences that he has had on his own. So, he becomes a new structure and as part and parcel he learns to adopt a heterosexual role and to find a kind of career in life and

all of these, as he tries and experiments, contribute to a sense of his own independent identity which is unique to him and different from everybody else.

In the course of this process, where he has to experiment and try, he is able to cope maybe better at some times than others because of his capacity and environmental demands which go back and forth. At this time one of the key contributors to this successful development, is the function of his parents.

In other words, I think the parents provide a vital, emotional function for the emotional equilibrium of the adolescent at this time for the process of emancipation and becoming independent and they perform this through, in general, stepping in at times when he is not managing with guidance or with control.

Q. Doctor, how does an emotionally disturbed adolescent differ from an emotionally disturbed adult?

A. One of the things that concerns me about this proposed change is that, as different as the adolescent—(248) normal adolescent is from the normal adult, the difference between the emotionally ill adolescent and adult is much, much greater. The reason being and I think this is a common error that everybody makes, because they are chronologically and physically adult, the assumption is made—the assumption is made they are chronologically adolescent, particularly those who come to the point where hospitalization is necessary.

These adolescents are not emotionally adolescent, they are infants. Their emotional development is infantile. Although they are six-foot-four and weigh 250 pounds, emotionally they are two or three years old, and

now, what does this mean in terms of their behavior and their observation? It means that when it comes to their management of themselves, the way they execute their own emotions and deal with their life stresses, it is dominated by a poor impulse control, poor frustration control, poor judgment.

These are all manifested in an inability to do what is essential for an adult and that is to select and choose among those impulses that they are bombarded with—which one they will express—depending on the gratification they may get and depending on the harmful effects if they do. They are left to the anarchy of their impulses. They cannot do this. When the impulse arrives, (249) it must be discharged regardless of the cost. So that, as I see it, in this suit, in which you are taking, as I see it, the authority away from the parent and handing it to the adolescent, you are giving this particular adolescent his civil rights at the cost of his human rights, I think.

His human rights being the right to the developmental influences necessary for his own development, and giving him this choice, it seems to me, must be based on the assumption that he has the capacity to exercise it in his own best interests.

If he had that capacity, I don't think he would be going into the hospital. He does not have that capacity and so, to give him a choice, I think does him a disservice by misperceiving what his basic emotional needs are and treating him as something he is not.

We have a word for it which is kind of fancy. We call it "adult Aphroditing the adolescent," treating him as an adult when he is not really. They respond to this

with a feeling of being neglected and not being seen for what they are.

This is kind of a phenomenon particularly with those who go in the hospital, which is commonly done by the parents in the kid's early life. It then becomes a repetition on a social level of, you might say, a (250) pathological phenomenon which already caused harm in a family at an early childhood level and it's now institutionalizing him and society is going to do what the parents did and have something to do with the harm in the beginning.

Q. When you have recommended hospitalization of the juvenile, do you find that the juveniles are objecting?

A. Yes, they almost always object.

Q. How do you interpret that objection?

A. Well, this, I think, is such a common phenomenon that we see all the time, you would have to conduct your own little experiment to see how true it is and how stereotype it is.

You see the patient during admission and you see, perhaps as little as ten minutes later, him again when you are on the floor. It comes down to the interpretation of the meaning of behavior.

It is not so much what he says but what he means. And if I may backtrack a bit to what I said a moment ago, because he is in this state that he is dependent upon the parent and does not want to change that, adolescents do not communicate their feelings directly and verbally. So that when they are in pain and are having trouble, they express it by an action and very often it can be an anti-social action. They feel at this point (251) that their parents are scapegoating or rejection is an indication that the parents don't care, but they can't verbalize this because this

means an admission that they would like the parents to care, but the parents don't, and they cannot tolerate it. The way they express it is in behavior .nd this is what brings them into the hospital.

This is a way of relieving the feeling the parent does not care—by forcing the parent to do what is necessary for the adolescent's well-being.

In other words, for the parent to do for the adolescent what he can't do for himself, which is saying, "You have to go into a hospital because you are sick and you need help," and for the parent to do it over his objections and that is why I think he says no.

As I say, it is so common, we prepare the parents after we have done the evaluation and we say—they are terribly guilty. We say, "Are you so guilty about me that if I put the heat on you, you won't do what is in my best interest? Then that means you don't care about me."

So we prepare the parents after we have decided on hospitalization. The adolescent comes back and he will say things like, "I hate you. I'll never speak to you. Don't you realize what you are doing? These people are going to imprison me. I am going to be (252) tortured," and the parents say, "I'm sorry you feel this way, but it is in your best interest." It is a play or charade. This goes on in the office and when we take a kid down on the floor it disappears and you can see the relief on his face and then they start testing us and then they come and tell us what was going on and why they had to do what they did to get the help they needed.

This is why they say no and I think, by the way, that this is why it should be the parent who says, "You have to

go in the hospital," and not the Court. The parent is providing an emotional function vital to the adolescent at that time and I don't think the Court can ever be an effective substitute.

Q. Do you interpret this rejection as a plea for help?

A. The behavior—in other words, the anti-social behavior, we have characterized as a plea for help, as a way of describing why they are doing it, the fact they cannot communicate directly—so their plea for help is indirect. It is so common, that we advise adolescent psychiatrists for example, to not try to force the adolescent to admit how much he hurts and needs help at that time, because it will just drive him away, but to recognize that it is his very behavior which is the plea for help and accept it and start to work on that level.

I have one example that might illustrate (253) this. I saw a boy who is 16 and he was arrested for stealing at a prep school and brought down to my office for evaluation. He told me this story:

When he was 12 years of age, his mother and father were divorced and he went on to live with the mother. Three months before the Christmas vacation he came home to stay with his mother and he and his mother had a fight and his mother kicked him cut and said he should go live with his father. He went to see his father and his father was living with his latest mistress in a hotel and had no room for him, and his father put him up in a hotel room and he spent the entire Christmas holiday reading a comic book and watching television and he went back to school and wrotc a theme which he was going to do. Then he started stealing articles from homes and he walked by a policeman and started stealing and was apprehended.

The parents were called and he took all of them to his dormitory and his footlocker, where he had carefully wrapped and stored everything, and this is how he got help.

Q. How do you feel about providing a hearing for an adolescent when the parent agrees with the recommendation of the psychiatrist to hospitalize their child?

A. To repeat what I said before, I am against it, (254) is as if their rights are not being respected, for us to act and to demand and require of them all kinds of conscious, verbal things that they cannot do and are not interested in, and it is a kind of vacillation in carrying out the effective role of the parent in dealing with the problem.

He's already made his statement in his behavior; why does he have to go into Court and go through the whole thing again?

Q. How would an unstable set of parents be operating in the best interests of their children?

A. Well, I think every parent of every patient we see can be called unstable, so that it is a more complicated phenomenon. They are all unstable in some ways.

Now, it depends to a great extent on the way in which their instability affects their role as a parent. There are some people who can, for example, be very effective at their work, but when they come home, they're hell with their children. There are others who after the kids go to bed at seven or eight o'clock at night, they are alcoholic all night; for the rest of the day they manage to perform a parental function.

It's a more complicated problem as to whether they are unstable or not. There are several things about this.

Even parents who are quite disturbed are generally (255) not disturbed all the time and even though a child may play, let's say, a pathological role in their life, for the most part, there is always a part where he does not.

It is over and above the fact that they do have problems. They also want to be a good parent; not just because they have this function now to perform, like to be a good lawyer or good doctor, but it seems to me there is something in the human personality because I hear this theme repeated over and over again. Once you have grown up yourself and once you become an adult, and have a child, one of the key motivating forces is you do not want to repeat the traumas on your child that you received yourself while you were growing up, no matter how large or small, so this also motivates them.

Q. Doctor, do you believe there should be different admission procedures for adults than for juveniles?

A. Yes.

Q. Why?

A. It seems to me I have said it already.

For the same reasons. I think they are different and I think we should recognize this difference and it should be reflected in the law just as it is reflected in psychiatry. For example, we now instead of having the adolescents with the adults in the hospital, we have them in their own unit because this reflects their emotional (256) needs.

Q. Doctor, in Pennsylvania, we provide a hearing for a juvenile age 13 to 18 if he objects at, or subsequent to, admission.

Do you feel that hearing is harmful at that time?

A. I think it can be harmful. It's not necessarily harmful. I think it's a different cup of tea than having a hearing before he gets into the hospital, because those

dynamic and emotional functions that I have mentioned have already been performed. The patient has made his statement in his behavior and the parents have responded and that framework has now been set up for treatment and for, you know, dealing with the problem. Once he gets into the hospital and then he wants out or he wants a hearing, the parents are more or less out of it.

So I think it is a different cup of tea. I think—I have often seen it be harmful where they are allowed out of the hospital and don't belong out of the hospital.

MR. ROTH: Your Honors, I have no further questions.

Cross-Examination

BY MR. FERLEGER:

Q. Dr. Masterson, the hospital or clinic that you have been discussing that you work at is the Payne-Whitney Psychiatric Clinic of the New York Hospital?

A. Yes.

Q. That institution, that Payne-Whitney Clinic, accepts adults as well as children?

A. Yes.

Q. And, the total population, adults plus children, is just over a hundred; is that right?

A. Yes.

Q. And, the total number of high school aged kids is about eleven; is that right?

A. It averages about that. Sometimes more.

Q. Do you have children there, younger than high school age right now?

A. No.

Q. Do you accept children younger?

A. No.

Q. And, the cost per day is about $180.00 per day; is that right?

A. Yes.

Q. It's more than the Institute here in Pennsylvania; isn't it?

A. What is that?

Q. The Institute—

A. I know. What is the cost?

(258) Q. $120.00.

JUDGE BRODERICK: That was the charge, not the cost.

MR. FERLEGER: Yes.

Q. How many psychiatrists are on your staff that are mainly concerned with the eleven or so juveniles that you have?

A. Well, we have a rather—maybe a unique arrangement. We have all the residents in training in their second year musing through the program, so that we have at any one time, we will have—if we have eleven patients, we will probably have eleven second year residents.

We will have two third year residents who we call the chief residents, who are administrators of the program and over and above them we have like five graduate psychiatrists who are supervisors.

Q. Did I understand you to say you have eleven patients, eleven psychiatrists who are residents, plus more than five supervisors and administrators?

A. That's right.

Q. Is there any institution that you know of with a greater doctor-patient ratio?

A. No.

Q. Doctor, you heard me earlier ask Dr. Miller—

A. Let me, if I may, briefly elaborate—

(259) Q. Can you wait to elaborate—

JUDGE GIBBONS: If it relates to the previous answer, elaborate now.

A. There is a reason. We have a one-to-one—because of what we are teaching, we are trying to teach intensive psychotherapy which requires intensive contact over a long period of time so they only get one patient, you see, and if they were getting lots of patients, if they had a lot of patients, the ratio would be quite different.

Q. Most state facilities do not involve the teaching of psychotherapy on that long a basis; is that right?

A. That's correct.

Q. Doctor, in the introduction to the book you edited, Teaching and Learning Adolescent Psychiatry, that I mentioned earlier, you note with apparent approval and your words are, and if you'd like to see the book, I have it here for you.

A. Yes, I'd love to. It's been a long time.

Q. To refresh your recollection (indicating), your words are, "In Georgia, the governor has just signed to law a provision that teenagers may get psychotherapy without the permission of their parents."

Do you approve of such a law?

A. I don't know if I approve of it in that form. I do think that they should be able to apply for help without (260) permission of their parents.

Q. Now, Doctor—

MR. ROTH: Excuse me, had you finished with your answer?

THE WITNESS: No.

A. Then, I think what should happen is that at the appropriate moment—in other words, the psychiatrist should be able to see them without having parental permission first. At the appropriate moment in the evaluation the parents should be brought in and hopefully there would be a consensus among them as to the need for treatment.

Q. If there's a disagreement?

A. I would be in favor of a hearing.

Q. If the child felt that the child needed help and the parents said no.

A. And the psychiatrist thought the child needed help a hearing would be in order.

Q. Even though that hearing might conflict within the parents duties and role as a parent?

A. Yes. May I give you the reason because it sounds like a contradition. It isn't.

I think in medicine in general, there is a conservative principle of treatment and that is that you don't do any more than you have to do—you don't take any more risks or take on any more possibilities (261) of danger that you have to take in order to deal with the problem at hand. I don't think the family unit should be disturbed for the reasons I mentioned. However, under certain circumstances which go beyond that, in other words, there will be greater harm in not doing this than in doing it, I think it should be done. That is one of the examinations.

Q. It is true in many cases of children who have emotional problems as one described in your book, Borderline Syndrome. In those cases the parents are not good observers of the child's symptoms; is that true?

A. Yes.

Q. In fact the parents may have been unconsciously provoking the behavior of the child.

A. Yes.

Q. This would apply to the anti-social or acting-out behavior we have talked about?

A. It could, yes.

Q. Now, Doctor, there will also be many cases where the child may be driven to such behavior by the conflicts at home, isn't that right?

A. That also can happen.

Q. Now, there is a phenomenon, Doctor, in psychotherapy which I am certainly not an expert on, called "counter transference," where psychiatrists have difficulty dealing (262) with the conflicts aroused in themselves by their parents' needs and desires.

Isn't it true, Doctor, that in this situation the psychiatrist may become unable to recognize or to explore the patient's conflict in some situations?

A. This is a possibility, sure.

Q. In those situations, the psychiatrist's difficulties in perceiving what is going on can block therapy and result in an improper evaluation; isn't that so?

A. That's true. I'd like to add to that.

It seems to me here, you are not talking so much about psychiatrists, but you are talking about human nature and I think that phenomenon you have described can occur anywhere.

Q. I agree.

A. And—all right.

Q. Doctor, in situations where, for example, you have a schizophrenic evaluation of a child, you have found in your research, haven't you, that usually at least one of the parents has a pathological attitude toward the child; isn't that right?

A. That's right.

Q. And, that very often, the children are resentful and hostile towards parents, so there is a conflict?

A. That's right.

(263) Q. And usually, there is a rather overt conflict between the parents and the child; is that right?

A. That's right.

Q. Doctor, New York law, as you may be aware, allows for the commitment of anyone, adults as well as children, for that commitment to occur on a certificate signed by two doctors; is that the law in New York?

A. Yes.

Q. Do you believe that sort of admission procedure is a proper one?

A. Am I in favor of that for adults, for adolescents or for everybody?

Q. Right.

A. As I understand it, you are able to have them committed on two physicians' certificates for up to ten days when they must have a court hearing.

Q. Are you certain of that?

A. I am pretty sure of it. I am not certain of it.

Q. Well—

A. Yes, I am in favor of it.

Q. You are in favor of it for ten days or you would be in favor of it if it's indefinite?

A. No, not if it's indefinite.

Q. You would not be in favor of two doctors' certificates for indefinite periods?

(264) A. No.

Q. How about for children?

A. The parents should have to perform this function, and if the parents do not, the Courts should.

Q. Having two doctors' certifications for an indefinite commitment of a person under 18; are you in favor of that?

MR. ROTH: Objection, your Honor. I believe he has answered that question.

JUDGE GIBBONS: No, I don't think he did with respect to the people under 18.

MR. ROTH: I think he addressed himself to juveniles under the distinction.

JUDGE GIBBONS: It certainly isn't clear to me.

Another thing that isn't clear is, you have shifted ground from what the Doctor perceives to be the New York statute which has a ten-day limitation and an indefinite stay.

MR. ROTH: We can refer later to what the New York statute says. I am asking the Doctor whether he wouldn't agree—

JUDGE GIBBONS: I want to be sure that the record is clear in each answer.

Q. Let me repeat the question, Doctor, and make it very clear.

(265) Without reference to the particular provision under New York law, would you favor two doctors' medical certifications for commitment of persons 18 or under for an indefinite period?

A. No.

Q. Would you favor commitment of juveniles with two doctors' certifications with the parents' application for an indefinite period?

A. You are assuming here, that the adolescent objects?

Q. That's correct.

A. No, I think he should be put in the hospital and then I think he should have a hearing.

Q. So, you do not feel then, that just because the parents and the doctors want the child in the hospital, that should be enough reason to keep the child in without a hearing? You do feel a hearing should be provided if the adolescent objects?

A. That right.

Q. Even if that objection comes from this adolescent confusion and turmoil?

A. I think, and it has been my experience, and we have had it in our unit, that since it is an integral part of what is wrong with him, this law has given a weapon to this type of thing where he will sign out—

Q. What do you mean?

(266) A. In New York State we have a law that after they are admitted, if they want to leave, they sign a letter and within 24 hours they must be given the services of a lawyer from the mental health commission and either, in three days, we either have to commit them on the two physicians' certificates or we have to let them go.

Q. Do you feel it's destructive?

A. To them, yes.

It's not until they get through the testing phase of their treatment and get into the relationship and start to work on their problems that they realize the function of what they are doing.

Q. How long does the testing phase take?

A. Three months to six months.

Q. You would be in favor of them not getting the hearing until three months or six months later?

A. Yes. You take this rebellious and negativistic testing teenager who is in the first phase of treatment, all you are talking about is why did he did this and that, and once that happens, you get control of the behavior and once he feels he can trust you and he thinks you know what you are doing and he has not met many adults whom he's had the right to feel that way about them, the whole picture changes and he goes back and reviews everything that has happened and I think I have documented that in this book, (267) and he tells you exactly what he was feeling, which he was unable to say before, and he describes these and at this stage in the treatment if he went before a Court I think he knows and is able to act in his best interest.

Q. So, you would feel that Pennsylvania regulations which allow hearings to be requested within a couple of days, that those would also be destructive?

A. I think they could be very destructive.

Q. Doctor, one further question; it is more a request for an explanation.

You stated in your article in the American Journal of Psychiatry in 1967, "Symptomatic Adolescent Five

Years Later," you said, "I consider, unless I can prove otherwise that my patient has a psychiatric illness."

Now, do you feel that other psychiatrists also share that basic presumption of a psychiatric illness unless it is proven otherwise?

A. I think you have to understand that comment in the context with which it was made, and at the time in which it was made. When I first started in adolescent psychiatry, the dominant theme in the field and that's how this paper is an outgrowth of like ten years of research on this question, the dominant theme in the field was when you see an adolescent, most likely, what is wrong with him has to do with the fact, you know, that he is (268) in this growth stage and it is probably due to that and when he gets over that, it will disappear. And, this attitude on the part of adults towards adolescents goes all the way back to Socrates. However, it was in the literature and it was probably by far the most dominant theme. The result being when adolescents came for evaluation, first of all they were difficult to evaluate and also at that time, we didn't know anywhere near what we know now, there's been such a knowledge explosion in adolescent psychiatry in the years I have been in it, so the psychiatrist was feeling insecure.

So what did he say? "Don't worry about Johnny, he is an adolescent, and when he gets over this he will be better," and every year Johnny's pathology is getting worse and worse and at age 22, after five years and he is out of his adolescence, he is now in a state hospital with a very long term.

All right, this was the context and I did the study and found out it was never growth, it was always psychiatric illness. The psychiatrist should not be thinking about growth but he should be thinking about illness, and the burden of proof should be on him to show the guy is not ill.

Q. The burden of proof on the psychiatrist or patient?

A. The psychiatrist.

(269) Q. The psychiatrists should first assume the person is ill and then try to prove otherwise?

A. I think he should—if we are talking about an adolescent, I think he should assume for the purpose of his own intellectual processes that this phenomenon is more likely illness than growth and then rule out illness and then come to the conclusion of growth rather than the other way around.

Q. Just one final question.

The testing phase you described, this process where at first people say, "I don't want to be in the hospital. I didn't act crazy."—do these things— and then after a while they begin to gain what doctors often call "insight" into their behavior; that happens with adults, too, does it not?

A. Sure.

Q. So, you may have for example, and if this is correct, I have had clients that have been involuntarily put into mental hospitals and after a few months of protesting and not getting out, they suddenly say, "Yes, I really am sick;" isn't that right?

A. Yes, certainly.

Q. So, would you feel then, that the law should also, as is said for juveniles, that adults should not be able to request an automatic hearing until after the testing (270) phase for adults is concluded?

A. I would feel what you have there is an adolescent adult and I would hope this is an exception.

This phenomenon is common; it is part of adolescence. It is not the part of the adulthood.

MR. FERLEGER: No further questions.

MR. ROTH: Just one question.

Redirect Examination

BY MR. ROTH:

Q. In the event a parent brings his or her child to you and you recommend hospitalization and the parent objects to it and the child is indifferent towards it, but is definitely in need of care, what can you do to make sure the child receives care?

A. This will depend upon the degree of need on the part of the child.

Q. Let us assume the degree of need is great, where you would feel professionally badly if that child did not receive hospitalization promptly.

A. The first thing I would try to do is work more with the parents so to see if I can get them to accept it.

If I could not get them to accept it, depending on how bad it is, there's a—I can't remember the name. There's an agency you can call and they will send a social worker in to investigate the family and to (271) take a role in this determination.

MR. ROTH: I have no further questions, your Honors.

JUDGE GIBBONS: Thank you, Doctor.

JUDGE BRODERICK: Good to see you.

THE WITNESS: Nice to see you.

(Whereupon, the witness left the stand.)

MR. ROTH: We did not bring the third witness with us today. We anticipated calling him the first thing on October 7th.

JUDGE GIBBONS: You will get one additional witness.

MR. ROTH: We will have an expert and one witness testifying as to the introduction of the effectiveness of the regulations since they have been published in September of 1973.

MR. FERLEGER: I understand that Mr. Roth is referring to the Exhibit that we discussed on Monday, which lists institutions around the state and I cannot see how one witness can be competent to testify to anything except that he made some phone calls.

JUDGE GIBBONS: I notice that you may have an evidence problem. Will you have any reputable testimony?

MR. FERLEGER: No, your Honor. We have (272) given the Court our Exhibits which are already numbered seven—Dr. Armstrong's deposition—and as soon as we get it signed, we will be submitting Dr. Finer's deposition, which the Court has already ruled can be admitted as a trial deposition.

That will be all the evidence from the plaintiffs.

JUDGE GIBBONS: And both sides will be prepared to present concluding arguments on the 7th, and we will finish the case that day?

MR. FERLEGER: Yes, your Honor.

MR. ROTH: Your Honor, if I may, with regard to Dr. Tashjian's Curriculum Vitae, I would like to have that marked as defendants' Exhibit 10, and on October 7th I will be prepared to introduce additional Exhibits for your ruling.

JUDGE GIBBONS: All right.

(Whereupon, the Curriculum Vitae of Dr. Tashjian was marked defendants' Exhibit 10 in evidence as of this date.)

JUDGE GIBBONS: We will recess then, until the 7th.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you, your Honor.

(Whereupon, at 12:17 p.m., Court was adjourned.)

EVIDENTIARY HEARING

Before: Hon. Daniel H. Huyett, 3rd, J.

Third Day

Philadelphia, Pa., October 7, 1974

(10:00 A.M.)

Present:

David Ferleger, Esq., Attorney for Plaintiffs, Mental Patient Civil Liberties Project, Philadelphia, Pa. 19107.

Barry Roth, Esq., Assistant Attorney General, Attorney for Defendants, Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa. 17120.

(275) (All Counsel being present, the following transpired in open court:)

THE COURT: Good morning, gentlemen.

MR. FERLEGER: Good morning, your Honor.

MR. ROTH: Good morning, your Honor.

THE COURT: It is my understanding from information given to my office last week, that the defendants have no further testimony and if that is the situation, then, we are concerned with closing the record today and determining the admissibility of exhibits, setting a briefing

schedule after the notes of testimony have been transcribed.

Is there any comment from Counsel?

MR. FERLEGER: That is my understanding, your Honor.

MR. ROTH: That is correct, your Honor.

THE COURT: All right, very well.

Perhaps we could determine what exhibits have been admitted and we can start from there. According to my notes, Exhibit P-1 has been admitted; P-4 has been admitted; P-5 has been admitted and P-6 has been admitted.

Also P-8 has been admitted, and on the defendants' side, my notes indicate we have admitted D-10, D-11, and D-12.

Would Counsel agree with me on that?

(276) Are there any others that have been admitted other than those that I have mentioned?

MR. FERLEGER: I don't believe so, your Honor.

MR. ROTH: No, your Honor.

THE COURT: What other exhibits are we concerned with today, gentlemen?

MR. FERLEGER: For the plaintiffs, Exhibits 2 and 3 were presented to the three-Judge Court at our last hearing and I believe Judge Gibbons commented the Court would reserve ruling on plaintiffs' Exhibits 2 and 3.

THE COURT: What are 2 and 3?

MR. FERLEGER: Number 2 I don't see any problem with, because it is part of the final order, stipulated

facts, the Governor's task force on mental health of children and youth. It is their report on the issues in this case and most of that report is already in the record in the final order.

THE COURT: Is there any objection, Mr. Roth, to the Exhibit P-2?

MR. ROTH: Your Honor, we had objected to the admission of that as being irrelevant.

THE COURT: Is that the only reason for not admitting it?

(277) MR. ROTH: Yes, your Honor.

THE COURT: How is this relevant, Mr. Ferleger?

MR. FERLEGER: Your Honor, it is relevant in two senses: One, because it is the report of an official task force of the Pennsylvania government which made a recommendation to the Department of Welfare, contrary to the regulations they adopted.

It is relevant, also, because just on its face, the arguments and the reasons it gives on behalf of its conclusions, it seems to me, may be permissive to the Court.

It is at paragraph 33 of the final order; most of the report is reprinted at that paragraph.

There is no objection by opposing Counsel to doing that.

THE COURT: Is this a matter that the three Judges specifically took up?

MR. FERLEGER: No.

MR. ROTH: No.

THE COURT: Counsel, a moment ago, stated that we would reserve our rulings on P-2 and P-3. Where did you get that from?

MR. FERLEGER: That is my recollection of the last hearing. I believe Judge Gibbons said to me, (278) "Is there any need to rule on P-2 and 3 at this time?" I answered that there wasn't and I believe that he said that the Court would wait.

THE COURT: Your only objection, Mr. Roth, is relevancy?

MR. ROTH: Yes, and if I may, there has been a mistake in that this is not the Governor's task force. It is the task force on mental health in children and youth. It was not directed by the Governor's office. We have numerous task forces within the Department of Public Welfare which are convened to make recommendations to other councils in the department.

Their recommendations are not binding. It is merely advisory and we feel this report is irrelevant.

THE COURT: Is this the report of a private organization?

MR. ROTH: This is the report of a task force that was convened by the Secretary of Public Welfare of the Department of Public Welfare on children and youth. And they report directly to the Secretary of Public Welfare.

MR. FERLEGER: The defendants' second set of interrogatory replies responded that was an accurate copy of the task force report and gave information as to who the members of the task force were and how it was (279) appointed and to whom it made recommendations.

It seems to me an official government report on the propriety of the recommendations as to what are partly in dispute are extremely relevant to this case.

THE COURT: Any further comment from Counsel on P-2?

MR. FERLEGER: No, your Honor.

MR. ROTH: May I, your Honor?

THE COURT: Yes.

MR. ROTH: Thank you.

With regard to the substance of the report, I merely make one observation and that is that the plaintiffs in this lawsuit seek a judicial hearing for every juvenile whether they object or not and in that particular report, it addresses itself to whether or not a juvenile objects. So it is more restrictive than what plaintiffs seek.

I register an objection again, on the basis of the relevancy. Otherwise, we could provide numerous reports of every task force convened and I think it would not do this Court justice in that respect.

THE COURT: Gentlemen, I will take under advisement the admissibility of P-2.

What about P-3; is that the same thing?

MR. FERLEGER: With regard to P-3, there (280) is more of a problem. This is an affidavit which was filed with the Court some time ago, more than a year ago, I believe, when we mentioned it in our proposed final order and Mr. Roth stated he did not know it was in the record.

Dr. Ginsburg, as I told your Honor at our conference in chambers on the final hearing order, is in South America.

He left, I think, the beginning of August and was unable to be here to testify. The content of his affidavit in a way is a statement of his feelings as an expert on the various matters involved in the commitment of children.

We think that this may be of assistance to the Court.

THE COURT: Mr. Roth?

MR. ROTH: Thank you, your Honor.

Again, we objected to this, and first, may I state for your Honor that we had not received a copy of this when it was allegedly sent a year ago and we had brought this to Mr. Ferleger's and the Court's attention when the prehearing order had been drafted.

Upon reading that, we would have continued to object had we noted it a year ago. We found it was irrelevant; that the document, itself, could not be cross-examined; and as your Honor well knows, there (281) have been several experts who have testified and we feel their testimony would be the best evidence, since both parties have had a chance to directly and cross-examine those witnesses.

THE COURT: Anything else on P-3?

MR. FERLEGER: I hope Mr. Roth applies the same reasoning to his affidavits.

Nothing more on P-3.

THE COURT: We can't have this admitted by stipulation, in other words?

MR. ROTH: I would not be willing to, your Honor.

THE COURT: I will take the admissibility of P-3 also under advisement.

What else do we have, gentlemen?

MR. FERLEGER: Your Honor, the plaintiffs have two depositions, which by the pretrial order, I believe were ordered to be admitted.

One is the deposition of Dr. Barbara Armstrong, and I guess we should take that up first.

Mr. Roth sent me, and I just received today, a letter objecting to the underlining on about five or six of the pages. I think we can either resolve which lines are to be underlined or I am willing to omit those entire pages so we don't have to waste time.

(282) THE COURT: What is the purpose of the underlining?

MR. FERLEGER: To eliminate colloquy and other irrelevant matters from the deposition.

THE COURT: There is no question on the admissibility of the deposition? Counsel attempted to purge portions which were not of material importance and which we were not concerned with and this is the hang-up; is that correct?

MR. FERLEGER: Yes, there is only seven pages which there is disagreement on, and I am willing to omit those pages, if Mr. Roth is, because there is no necessity to worry about one or two lines.

THE COURT: What are you agreeing to?

MR. ROTH: Your Honor, it is my understanding, according to your order of August 21st, that we would underscore the portions agreed upon—

THE COURT: The underscored portions should be purged and not considered?

MR. FERLEGER: The underscored portions should be considered and those parts disagreed upon we subsequently resolved that by underscoring those parts in accordance with your order.

THE COURT: If you can't agree, it is admitted.

(283) MR. ROTH: Yes.

THE COURT: Can Counsel work this out and file something?

MR. ROTH: I can agree with Mr. Ferleger on admitting those parts that he has just addressed himself to.

MR. FERLEGER: Can we agree to admit the entire pages?

MR. ROTH: That would be fine.

THE COURT: For the record, what is the number of this deposition?

MR. FERLEGER: My copy—I don't have a number on this. Since it has not been admitted, your Honor, perhaps I should give it a number.

THE COURT: Is this a plaintiffs' exhibit?

MR. FERLEGER: Yes. The last one we have is number 6 and number 8 was a brochure from the Institute of Pennsylvania Hospital. So, I believe this may be number 7.

THE COURT: Number 7 is the accreditation manual for psychiatric facilities and number 8 would be the brochure from the Pennsylvania Hospital which was admitted. Would this be P-9?

MR. FERLEGER: Yes.

THE COURT: All right, the Armstrong (284) deposition will be P-9.

MR. FERLEGER: For the record, plaintiffs move the admission of P-9 with the parts that are underlined in the Court's copies to be admitted with the exception of the following pages, all of which are to be admitted: All of pages 11, 28, 30—

THE COURT: Just a moment. 11?

MR. FERLEGER: 11, 28, 30, 55, 64, 67, 68, and page 123. For those pages, the parties agree that the entire pages are to be admitted.

THE COURT: Do you have any comment on that, Mr. Roth?

MR. ROTH: No, you Honor. That is fine with us.

THE COURT: In other words, the entire deposition would be admitted—let me start over again.

The Armstrong deposition is Exhibit P-9 and those parts of that deposition which are underlined are to be admitted and in addition, pages 11, 28, 30, 55, 64, 67, 68, and 123?

MR. FERLEGER: That's correct.

THE COURT: All of that will be admitted in evidence?

MR. FERLEGER: That's correct.

THE COURT: Fine.

(285) (Whereupon, the deposition of Dr. Barbara Armstrong as outlined above, was received in evidence and marked as plaintiffs' Exhibit 9 as of this date.)

THE COURT: What else?

MR. FERLEGER: Plaintiffs have one further exhibit which has been docketed and copies have been sent to the members of the Court. I was told before you came in that the originals are probably in your chambers.

It is the deposition of Dr. Joel Finer, which by the pretrial order was ordered to be admitted. It has been signed and sent to the court reporter for certification and filing and that deposition, which I believe your law clerk has, I move to have admitted.

THE COURT: This is document 80 in the file of the clerk?

MR. FERLEGER: Yes, I believe so.

THE COURT: Deposition of Dr. Joel S. Finer, M.D., taken August 21, 1974.

Any comment, Mr. Roth?

MR. ROTH: No.

THE COURT: Shall we mark this P-10?

(Whereupon, the deposition of Dr. Joel S. Finer, M.D., was received and marked in evidence as plaintiffs' Exhibit 10.)

(286) MR. FERLEGER: Plaintiffs have no further exhibits or testimony in this matter.

THE COURT: All right, thank you.

MR. ROTH: Your Honor, I have one question, if I may, regarding plaintiffs' exhibits.

I am not certain which plaintiffs' Exhibit 7 was.

THE COURT: According to my notes, it is a manual of accreditation for psychiatric facilities.

MR. FERLEGER: That's correct, your Honor. The record will indicate that it is the Joint Commission on Accreditation of Hospitals' new manual on psychiatric facilities for children and adolescents.

Dr. Kandler, I believe, in his testimony referred to it and it was marked for identification only and was not admitted as an exhibit.

THE COURT: In other words, P-7 was not admitted?

MR. FERLEGER: That's correct, your Honor.

THE COURT: All right.

MR. ROTH: Your Honor, we would object to that—

THE COURT: It is not admitted. It is just simply marked. It is not part of the record.

(287) MR. ROTH: Fine.

THE COURT: Plaintiff has nothing further to offer by way of exhibits?

MR. FERLEGER: That's correct, your Honor.

THE COURT: Mr. Roth?

MR. ROTH: Thank you, your Honor.

We have prepared a list of our exhibits which we sent your Honors and Mr. Ferleger and it is my understanding that there is no disagreement and the following can be introduced into evidence:

Defendants' Exhibit 1—

THE COURT: Will you describe briefly each one?

MR. ROTH: Fine.

THE COURT: And at the end of each exhibit, we will consider the admissibility of each exhibit.

MR. ROTH: Thank you, your Honor.

Exhibit 1, your Honor, is the May 31, 1973 questionnare submitted to all mental hospitals, state schools and hospitals regarding impatient psychiatric care. There were numerous questions on that particular questionnaire which were responded to.

THE COURT: Any objection to D-1?

MR. FERLEGER: D-1 is the questionnaire (288) that was sent out in response to the Court's order that plaintiffs' interrogatories be answered and we have no objection to their questionnaire being admitted.

THE COURT: D-1 is admitted.

(Whereupon, D-1, previously marked for identification was now received in evidence.)

MR. ROTH: D-2, your Honor, are the additional procedural safeguards for juveniles admitted to institutions and so labeled and found in the Pennsylvania Law Bulletin, Volume 3, Number 37, adopted September 1, 1973.

There is a mistake on the cover sheet of the defendants' exhibits which I prepared which says September 1, 1974. It should read, "September 1, 1973."

MR. FERLEGER: No objection, your Honor.

THE COURT: D-2 is admitted.

(Whereupon, the so-marked D-2 is received in evidence.)

MR. ROTH: These exhibits were agreed to in the prehearing order. Defendants' Exhibit 3 are the answers to the questionnaire of May 31, which also was agreed to in the prehearing order.

THE COURT: Any objection to D-3?

MR. FERLEGER: No, your Honor. I understand D-3 is the very large volume of responses by each (289) institution about children in mental hospitals and we have no objection.

THE COURT: D-3 will be admitted.

(Whereupon, the so-marked D-3 is received in evidence.)

THE COURT: May I comment that Counsel should meet with my law clerk to make sure we have all the exhibits and they are all properly labeled, since this is getting to be a rather thick record; that we have all that we should have. I would appreciate that very much.

Would you continue, Mr. Roth?

MR. ROTH: Yes, your Honor.

Exhibit 4 is the admission note of Donn Dickel, which I understand there is no objection to.

MR. FERLEGER: There is no objection to Exhibit 4, your Honor.

THE COURT: D-4 is admitted.

(Whereupon, the so-marked D-4 is received in evidence as of this date.)

MR. ROTH: Defendant 5 is the admission note of Alan Moss which I understand there is no objection to.

MR. FERLEGER: No objection.

THE COURT: D-5 is admitted.

(290) (Whereupon, the so-marked D-5 is received in evidence.)

MR. ROTH: With regard to Defendants' Exhibit 6 and 7, which we had alerted your Court to a few weeks ago, we wish to withdraw those exhibits.

THE COURT: Very well.

MR. FERLEGER: Which exhibits?

MR. ROTH: Dr. Kratsa's affidavit of Alan Moss and Dr. Gus Kratsa's affidavit of Don Dickel.

Exhibit 6 would now become patients profiles which were agreed upon in the prehearing order and we have received no objections to that.

MR. FERLEGER: There is no objection, your Honor.

THE COURT: The new D-6 is admitted.

(Whereupon, the so-marked D-6 is received in evidence.)

MR. ROTH: Defendant Exhibit 7 would be the pretrial deposition of Dr. Max Sugar.

MR. FERLEGER: No objection to Dr. Sugar's deposition.

THE COURT: D-7 is admitted.

(Whereupon, the so-marked D-7 is received in evidence.)

MR. ROTH: Your Honor, if I may state (291) for a moment here, with regard to the Curriculum Vitae of the three expert witnesses, as is recalled, we admitted them as Defendants' Exhibits 10, 11, and 12.

However, our numbering is now going to be augmented, since we have withdrawn Exhibits 6 and 7.

Shall we renumber those exhibits?

THE COURT: No, they can remain 10, 11, and 12. It might be confusing to renumber them.

MR. ROTH: Your Honor, shall I reflect what those exhibits were, 10, 11, and 12, if there is any problem?

THE COURT: You might for the record.

MR. ROTH: Thank you, your Honor.

For the record, Exhibit 10 is the Curriculum Vitae of Dr. Levon Tashjian. Exhibit 11 is the Curriculum Vitae of Dr. Derek Miller, and Exhibit 12 is the Curriculum Vitae of Dr. James Masterson.

Your Honor, Defendants' Exhibit 13 is ten other states' admission policy regarding juveniles. In particular, they are the laws of ten other states which we would respectfully request that this Court take judicial notice thereof.

THE COURT: Any objection?

MR. FERLEGER: I don't object to the Court taking judicial notice of any state statutes.

(292) I do object to Mr. Roth selecting which statutes are selected. I don't believe this is a proper evidentiary exhibit, because it does not tend to prove any fact in this case.

THE COURT: D-13 is a compilation of other state statutes. D-13 will be admitted and if you wish to argue any other statutes, Mr. Ferleger, you may do so.

(Whereupon, the so-marked D-13 is received in evidence.)

MR. ROTH: Defendant Exhibit 14 is labeled "Pennsylvania Laws Affording Adults' Rights While Not Visiting Similar Rights Upon Juveniles."

Again, we would request that this Honorable Court take judicial notice of those laws.

MR. FERLEGER: Your Honor, again, I am not sure of the accuracy of the compilation. It is a selection from Pennsylvania Statutes that the defendants have made. I don't know if they are accurate. I don't know if there are other laws which also involve juveniles that have not been included and I think the Court can take its own judicial notice of whatever laws in Pennsylvania exists.

THE COURT: Mr. Roth?

MR. ROTH: Your Honor, Mr. Ferleger has (293) been apprised of this summary as early as March, I believe it was, of 1973, when I attached a copy of these laws to my motion to my memorandum of law and we merely updated them.

The compilation has been prepared with our office and the Attorney General's office. Certainly, if there are other laws we have left out, we would be more than happy to have these admitted, also.

MR. FERLEGER: Let me just note that the exhibit itself is labeled with the labeling consistent with what Mr. Roth has labeled it.

Exhibit 14 is labeled, "New Laws Lowering Age Limit From 21 to 18 Years." So these are not laws not giving juveniles rights. These are new laws passed by the legislature all in 1972, involving lowering of age limits from 21 to 18. That takes us even further afield from this case.

There are laws about engineers having charge of steam boilers and insurance agents and assessment of taxes; laws involving second class cities and incorporated towns. These are those new laws that the legislature passed involving age limits and lowering of age limits. I don't see what this has to do with this case.

THE COURT: Mr. Roth, you are representing (294) D-14 as accurate and correct and you believe relevant?

MR. ROTH: Yes, your Honor. We feel that these laws reflect when one is 18 years of age or older, what he or she may or may not be able to do in accordance with the laws of Pennsylvania, while not visiting similar rights upon those younger than 18, which we feel is a very significant point in this lawsuit.

THE COURT: Well, to resolve the matter, gentlemen, and consistent with my ruling on D-13, I will admit D-14.

If any part of D-14 is not accurate or correct, I assume plaintiff will point that out in plaintiff's brief.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you.

(Whereupon, D-14 is marked in evidence.)

MR. ROTH: With regard to Exhibit D-15, your Honor, this is reflected as to how the September, 1973,

regulations are working as of April 2, 1974. At this time, I would like to introduce in accordance with this exhibit an affidavit prepared by Mr. Ralph Phelleps and Mr. Richard Barbush.

If I may explain the purpose of this first—

THE COURT: Yes. Then you may respond, (295) Mr. Ferleger.

MR. ROTH: Thank you, your Honor.

Your Honor, in September, 1973, we published regulations which basically permit juveniles a hearing, age 13 to 18, if they object at or subsequent to admission. Prior to an April 16, 1974 hearing, I had requested the Office of Mental Health to ascertain how these regulations were working. At that time, Mr. Ralph Phelleps, who was in charge of the collection of this particular datum, proceeded to collect the same. He outlines exactly what his procedure is in outlining that data.

He worked jointly with a person from the Office of Mental Retardation. The reason I bring these affidavits and not the people themselves is because I think the people themselves would merely testify as to the procedure utilized.

In other words, Mr. Phelleps, as is indicated, prepared with Mr. Barbush, as is indicated, the questionnaire letter to be sent. That letter was sent to the regional Deputy Secretaries to the attention of the Regional Commissioners. And they in turn notified the superintendent and administrators of the state institutions and subsequently the superintendents of the institutions and administrators delegate a staff member (296) to collect that data. After the data is obtained at the state or private institutions, it

is provided to the appropriate retardation and mental health commissioner who in turn forwards it to Mr. Phelleps' and Mr. Barbush's office, and this will show also the letter drafted by these two gentlemen which was sent out over the signature of Mr. Gregory L. Coleman, the Deputy Secretary and we submit this is an ordinary business practice in Pennsylvania to disseminate or obtain information from our facilities.

We realize the best way to present this would be to bring the person who collected the data from each institution. As I may recall the Court's attention, there are 20 state schools and hospitals and 10 state mental hospitals and 164 private licensed facilities. We would respectfully request that this exhibit be introduced.

THE COURT: Along with the affidavits?

MR. ROTH: Yes, your Honor.

THE COURT: And this is D-15?

MR. ROTH: Yes, your Honor.

THE COURT: If I were to rule against you, how would you then have to get this evidence in the record?

MR. ROTH: I think the only other way (297) to present this evidence would be to bring in the person from the various institutions and I am somewhat dismayed to have to say that.

I did indicate to your Court we would not bring in any other witnesses. We feel this may be an exception to the hearsay rule, if you will, based on the customary practice.

THE COURT: Mr. Ferleger, what comment do you have?

MR. FERLEGER: I have a number of comments, sir.

First, the hearing originally scheduled for this morning before the three Judges was to include testimony by the affiant here, Mr. Ralph Phelleps. I understood Mr. Ross was foregoing his testimony and it was implied to me, at least, there would not be any necessity for that exhibit to be introduced.

Mr. Roth was on notice, of course, because at the last hearing we had with regard to this hearing, Judge Gibbons stated at page 7, on the sixth line or so:

"I think he would be entitled to cross-examine. The summary could go in if you had a witness here that he could cross-examine. I don't think it could otherwise."

(298) THE COURT: This is specifically on this exhibit?

MR. FERLEGER: That's correct.

Further down, Judge Gibbons stated:

"I think you had better produce the witness and lay the groundwork for the introduction of the summary so Mr. Ferleger can cross-examine and object."

I am not sure what customary business practices are and I don't believe an affidavit submitted to a Court can be considered a business record.

In addition, Mr. Roth's summary of the affidavit indicates that we have, by my count, a fifth level of hearsay in terms of this affidavit and the information that it presents. Also, the Court may recall that at an earlier hearing, I indicated that two cases in which I personally represented juveniles who objected were not listed in that summary. So that I, personally, know for a fact that the summary is not accurate or at least I have indications to that effect and I certainly could not agree it could go in.

I don't understand Mr. Roth suddenly presenting this affidavit when he knew that he needed testimony in support of his submission. I also don't see that it is relevant, whether regulations which are (299) challenged work or do not work or whether 20 juveniles object to admission, rather than 35 or 55, seems to me to be not really crucial to this case.

Mr. Roth already has testimony of Dr. Tashjian's about what happens at the Institute of the Pennsylvania Hospital and I have no idea what happens in the rest of the state. I don't believe this exhibit is any help at all, either.

THE COURT: What is the purpose of this exhibit, Mr. Roth? Why do you need it in the record?

MR. ROTH: Your Honor, the Commonwealth merely wishes to show that the regulations are being utilized and that juveniles who object at or subsequent to admission are being afforded hearings.

If Mr. Ferleger is willing to stipulate to that, certainly we will have no need to introduce this into evidence.

THE COURT: Mr. Ferleger is saying this may not be complete.

You are not saying, are you, Mr. Ferleger, that any part of this is inaccurate or correct? You are saying it is not complete; that there may be more cases than indicated in D-15?

MR. FERLEGER: Yes. D-15 indicates every child who objects is given a hearing when under (300) the regulations children may be released.

The cases I know involved children who were objecting and were released because the hospital decided not to go for a hearing and there are a number of cases which have notices as the facts.

I will stipulate a large number of institutions are using the regulations and a large number of juveniles who objected were given hearings. There is no question about that.

MR. ROTH: Mr. Ferleger has indicated that he has represented two clients who objected to institutionalization that are not on this list. Certainly, we are not apprised of that from any evidence being introduced.

MR. FERLEGER: If Dr. Phelleps was here I could examine him about whether he contacted the institutions that were involved in my cases and what their responses were.

It is indicated he got letters from the various places you have not submitted those letters. I have no idea what he is basing his affidavits on.

Your Honor, if I may, I think Mr. Roth is being a little overindulgent in saying that we need 300 witnesses. Mr. Roth could certainly submit to me the written responses from the institutions. He could (301) have done that months ago. He could have said that at the hearing a month ago when Judge Gibbons indicated he would have to bring the witness in.

MR. ROTH: Your Honor, may I?

THE COURT: Well, is there any—can Counsel agree on any of this?

In other words, hopefully, we are closing the record today. If there could be some agreement of some type,

it would be very helpful. I think there are technical problems as Judge Gibbons pointed out at the last hearing. Perhaps Judge Gibbons and Judge Broderick were not aware of the magnitude defendants would have to get this type of information into the record, and it seems that if defendants wish to get it into the record, somehow there should be a way of getting it in.

Is there any area of agreement by Counsel on D-15?

MR. FERLEGER: I don't believe so, your Honor. I understood that the defendant had foregone any further testimony in this case and I don't see that this affidavit is the basis for introducing the alleged facts that they want introduced.

MR. ROTH: Your Honor, we certainly did not, nor would we attempt to mislead your Honor and Mr. Ferleger with regard to our position—

(302) THE COURT: I am not concerned about that. I am sure you did not attempt to mislead anybody. Don't worry about that.

MR. ROTH: Thank you.

With regard to Mr. Phelleps, he can testify only to what is in the affidavit and I thought it would be more expeditious with providing you with the affidavit, indicating what he does in his customary business practice together with my understanding of the rules would be acceptable.

MR. FERLEGER: Mr. Phelleps has no personal knowledge of any of the facts that are in the exhibit which is the summary involved here. Mr. Phelleps sent letters to somebody else who sent them to somebody else and who

sent them to somebody else and it was delegated to a staff person and shipped up on the law.

I don't know if this was regular procedure. I don't know whether Mr. Roth wants evidence to prepare for litigation; whether Mr. Phelleps' normal job includes being an investigator for defendants' Counsel.

I don't believe this is a business record and I don't believe the facts in that summary can be admitted.

MR. ROTH: Your Honor, Mr. Phelleps has sworn in this affidavit to exactly what procedure (303) he generally utilizes in gathering and dispensing information and at my request, he gathered information regarding these regulations. Also, in accordance with the regulations, we had indicated to the public in the Pennsylvania Bulletin, that six months after publication of those records we would ascertain to see how they were working to determine whether or not we would hold public hearings.

So we respectfully request that this data be introduced into evidence and that Mr. Ferleger who does not seem to object to the accuracy as much as its completeness, if he would like to provide more information, certainly we would like to see that information and register if we have any objections to their introduction.

MR. FERLEGER: I don't know whether it is accurate. I know it is incomplete. I don't know how accurate it is.

THE COURT: Well, can Counsel agree that under the new regulations, there are juveniles, who at the time of admission did object and that petitions were then submitted and the patient was committed under Section 406 and this occurred at a number of the state hospitals

throughout the Commonwealth at various locations, as well as other types of institutions, such as private (304) mental hospitals?

MR. FERLEGER: Yes, your Honor.

MR. ROTH: I would be willing to stipulate—

THE COURT: Would this cover the situation?

MR. ROTH: Yes.

THE COURT: Would Counsel so stipulate?

MR. FERLEGER: Yes.

MR. ROTH: Yes, we shall.

THE COURT: Then there is no need to have D-15 admitted.

What else do you have?

MR. ROTH: With regard to our last exhibit, we wish to withdraw defendants' Exhibit 16, which was a summary of Dr. Sugar's pretrial deposition.

THE COURT: That is withdrawn. All right.

MR. ROTH: We have no other exhibits to introduce, your Honor.

THE COURT: Now, there are missing numbers, starting with D-8. There is no D-8 and D-9?

MR. ROTH: That's correct, your Honor.

THE COURT: May the record now be closed, gentlemen?

MR. FERLEGER: Yes, I just want to (305) mention, your Honor, something I gave your clerk this morn-

ing and Mr. Roth. At 9:15, in this morning's mail, your Honor, I received a copy of an opinion by the Supreme Court of Appeals in the State of West Virginia in a Habeas Corpus action, it is dated July 30, 1974, Hardway versus Flowers, and that Court ruled, a juvenile who is committed without a prior hearing and Counsel to a mental hospital, and it happened to be a very good mental hospital, according to the opinion, that that juvenile was denied due process and equal protection in her commitment.

The other matter I have, your Honor, is something that may have been overlooked in the transition from Judge Masterson to your Honor, and that is the motions to file a brief Amicus of the Youth Law Center in San Francisco. It was filed and Judge Masterson never entered an order on their request to file a brief and on behalf of them we move that be admitted.

THE COURT: Any objection, Mr. Roth?

MR. ROTH: I have no objection.

THE COURT: This is document 31 in the clerk's file, dated October 4, 1974, and it is a request to file brief on behalf of Youth Law Center and I will order now that this brief may be filed.

MR. FERLEGER: Thank you, your Honor.

One other matter which I am not certain (306) how the Court wishes to dispose of and that is that I was informed while I was writing my brief that the United States of America, through the Department of Justice in Washington, D.C., wishes to file an Amicus brief which was completed last week and I believe your clerk may now have more up-to-date information than myself; which will be filed with the Court today or tomorrow and I would

request at this time on behalf of the plaintiffs that the Department of Justice for the United States be given leave to file their brief.

THE COURT: Off the record.

(Discussion held off the record.)

THE COURT: Back on the record.

I will permit the filing of the brief by the United States Government through the United States Department of Justice and I understand such brief will be filed within the next day or two.

MR. FERLEGER: Thank you, your Honor.

I would like to discuss the briefing schedule. The notes of testimony will be filed shortly. The court reporter has done a good job in keeping current.

Do you wish to file a further brief on behalf of the plaintiff, Mr. Ferleger?

MR. FERLEGER: I do not anticipate filing any further legal argument unless some new cases come (307) down, but I would like to file proposed findings of fact and conclusions of law within, I would suggest, ten days to two weeks after the transcript is completed.

THE COURT: All right, I will permit you to file proposed findings of fact and conclusions of law within two weeks after the filing of the notes of testimony.

MR. FERLEGER: Thank you, your Honor.

THE COURT: How much time do you need, Mr. Roth?

MR. ROTH: Your Honor, we would like to reply to Mr. Ferleger's brief which we received Friday afternoon,

and also reply to the transcript with proposed findings of fact and conclusions of law. May we ask for ten days after receiving Mr. Ferleger's proposed findings of fact and conclusions of law?

THE COURT: Very well, you may have then ten days after Mr. Ferleger files his proposed findings of fact and conclusions of law to file a brief and whatever else you wish to file and I ask that you also file proposed findings of fact and conclusions of law.

MR. ROTH: Thank you, your Honor.

THE COURT: After the notes have been filed, we will put this down for oral argument before the three Judges. I think we need oral argument here.

(308) Anything else, gentlemen?

MR. FERLEGER: I just want to make clear that my understanding is that or my intention is that I will file my papers after receiving the notes of the evidentiary hearing and I don't expect to wait for this hearing on the evidentiary matters today, because I don't feel that is crucial.

THE COURT: Do you agree with that, Mr. Roth?

MR. ROTH: Yes, your Honor.

THE COURT: All we are concerned with today are the exhibits.

MR. ROTH: I have no problem with that.

THE COURT: You will file your brief within ten days after Mr. Ferleger files his latest brief.

MR. ROTH: Fine, your Honor.

THE COURT: All right, would one of you prepare an order to that affect? Who wishes to do that?

MR. FERLEGER: I will.

THE COURT: Anything else, gentlemen?

MR. ROTH: No, your Honor.

MR. FERLEGER: No, your Honor.

THE COURT: Thank you very much, gentlemen.

(309) Court is adjourned.

(Whereupon, at 10:55 a.m., Court was adjourned.)

DEFENDANTS' EXHIBIT NO. 1

QUESTIONNAIRE

Commonwealth of Pennsylvania
May 31, 1973

SUBJECT: Juveniles Admitted or Committed to MH/MR Facilities Under Sections 402, 403 and 406 of the MH/MR Act of 1966

TO: Regional Deputy Secretaries, MH and MR Commissioner

ATTENTION: Regional

FROM: William B. Beach, M.D., Deputy Secretary for Mental Health and Medical Programs

Edward Goldman, Commissioner for Mental Retardation.

THROUGH: Gregory Coleman, Deputy Secretary of Operations

The United States District Court for the Eastern District of Pennsylvania, relative to the case of Bartley v. Haverford State Hospital has ordered the Department of Public Welfare to obtain and submit to the Court the following information:

1) The names and addresses of all MH/MR facilities which provide inpatient care of juveniles (MH/MR institutions, private licensed MH/MR facilities, and psychiatric units not used primarily for emergency detention);

2) The number of juveniles admitted or committed under Sections 402, 403 and 406 of the MH/MR Act of 1966 during the calendar year 1972;

3) The number of juveniles in residence as of May 10, 1973, under Sections 402, 403 and 406;

4) Reason for juveniles' admission or commitment or precipitating behavior warranting admission or commitment;

5) Objection of admission or commitment and/or detention by juvenile patient;

6) Relationship of applicant;

7) Mental status, competency to make judgment at time of admission or commitment; and

8) A copy of each facility's admission policy.

Juvenile is defined as one who is 18 years or younger. In this case those who had reached their 18th birthday as of May 10, 1973 should be included. However, those turning 18 years of age prior to May 10, 1973 should not be included. If the individual is 18 years and one day, he is not considered to be a juvenile.

Enclosed is a form sheet with definitions outlining information required. Please send copies of this form to all facilities listed for your respective Region. For your information, we have enclosed a list of all those DPW facilities from which this information is required. Please note that we have obtained much of this information from the State Hospitals and State Schools and Hospitals. Therefore, you should only be concerned with all private licensed MH and MR facilities and those psychiatric units not used primarily for emergency detention.

It is absolutely necessary that this information be received in Central Office to the attention of Mr. Ralph

Phelleps, Office of Mental Health, Room 303, Health & Welfare Building, Harrisburg, Pennsylvania 17120 no later than July 2, 1973.

If there are questions, you may contact Mr. Phelleps at Telephone #787-5370 or Richard Barbush at Telephone #787-5102.

INFORMATION SHEET

Admission/Commitment of Juveniles

Definitions/Explanation

Juveniles—Those who are 18 years of age and younger. The individual is still considered a juvenile on his 18th birthday; however, when he becomes 18 and one day, he is no longer a juvenile but is considered an adult.

Number—Do not name the juvenile; use his or her case or file number.

Objection—We wish to know if the juvenile objected at his admission or subsequent thereafter to remaining in your facility. Indicate Yes or No or N.I. for not indicated in records.

Competency—Indicate only if juvenile objected, whether or not the juvenile had the mental capacity to make that judgment—Yes/No. If juvenile's behavior pattern causes him to be negative, indicate negative. If not revealed in chart, indicate N.I. for not indicated.

NAME OF FACILITY:

ADDRESS:

1. Number of Juveniles Admitted During Calendar Year 1972 Under

402 ————

403 ————

406 ————

If possible, indicate number of those remaining at end of year ————.

2. Number of Above That Were Readmissions

402 ————

403 ————

406 ————

3. List 402 Admissions By Case or File Number and Supply Appropriate Information.

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

CONTINUATION OF NUMBER 3. (List 402 Admissions by Case or File Number and Supply Appropriate Information).

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

4. List 403 Admissions By Case or File Number and Supply Appropriate Information.

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

CONTINUATION OF NUMBER 4. (List 403 Admissions By Case or File Number and Supply Appropriate Information).

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

5. List 406 Admissions By Case or File Number and Supply Appropriate Information.

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

CONTINUATION OF NUMBER 5. (List 406 Admissions By Case or File Number and Supply Appropriate Information).

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

6. Attach a copy of your Admission policy for juveniles and adults.

NOTE: For Numbers 3, 4, and 5, if more space is needed please attach extra sheets with appropriate headings.

DEFENDANTS' EXHIBIT NO. 4

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

HOSPITAL Haverford State Hospital

D . . . D . . .

Name
Case No. 10118 Page ———

ADMISSION NOTE: 3/1/73

D . . . D . . . , aged 14, admitted March 1, 1973, on a voluntary commitment to Bldg. #9. His previous behavioral history is complex, chaotic and has caused his family a great deal of concern and conflict. He has also been truant from school and he has refused to cooperate with out-patient psychotherapeutic attempts.

He is oriented in all spheres, he was initially uncooperative but eventually stated his opinion and limited understanding of his past behavior. There is a strong indication that he has a fragile hold on reality issues and seems relatively sad and confused.

Current plan is to admit him and see him as an individual patient and work separatedly at first with his parents. Plans are to use both male and a female therapist for D . . . . Defer competency as patient is not of age to drive.

IMPRESSION:

Adjustment reaction of adolescence.

Gus P. Kratsa, M.D.

cbw
RTS-112 not sent

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HOSPITAL Haverford State Hospital

Name D . . . D . . .
Case No. Page ———

Present: Drs. Kratsa, Armstrong and members of the Adolescent Service Staff.

NEW CASE CONFERENCE NOTE:

D . . . D . . . was admitted March 1, 1973. D . . . D . . . age 14 demonstrates a very difficult clinical problem. His outline in his admission note was referred for in-patient care by Dr. Bernard Kantor who felt that he was unmanageable as an out-patient and he was also chronically truant from school. During this hospital stay our plan is to someway initiate motivation toward a out-patient therapy and find a reasonable school that D . . . can evolve himself with for his future educational involvement. Our assessment of family process at this time is exceedingly pessimistic. Both of D . . . adopted parents have poor reserve both physically and emotionally and are in our opinion very likely unable to cope with the future demands that D . . . will make upon them upon discharge. We are therefore working very diligently towards a residential placement in a therapeutic facility similar to the Green Bank School which had been recommended to us by an outside consultant.

It was also important during this hospital stay to further assess D . . . neurologic status. Again we recommended that D . . . be evaluated by another neurologist in the community with currently completing his evaluation which will include a repeat of an EEG which was done here at Haverford and felt to be borderline.

DIAGNOSIS:

1. Multiple developmental deviation in multiple dimensions.

2. Unsocialized aggressive reaction of adolescence.

RECOMMENDATIONS:

We are recommending residential placement in a therapeutic school and continued psychotherapy for D . . . for an indefinite period of time. He is currently not cooperating with our program. He is not affectively accepting medication.

Gus B. Kratsa, M.D.

GBK/dmn.

DEFENDANTS' EXHIBIT NO. 5

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HOSPITAL Haverford State

Name M . . . A . . .
Case No. 9929 Page ———

ADMISSION NOTE

January 10, 1973

A . . . M . . . , age 15 years-10 months, referred from HUP following in-patient psychiatric evaluation. Had been in out-patient treatment at Hahneman prior to HUP admission. Current problem is difficult to assess without admitting A . . . for further observation. He is depressed and suicidal—has been especially pre-occupied with suicide, for the last few months.

Will be admitted to Building 4 with possible transfer to Building 9. Both parents and one of his 3 siblings were part of this evaluation.

(s) G. B. Kratsa
G. Kratsa, M.D.

1s

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HOSPITAL Haverford State Hospital

Name M . . . A . . .
Case No. 9929 Page ———

NEW CASE CONFERENCE NOTE:

Present: Drs. Armstrong, Kratsa and members of the Adolescent Service.

A . . . M . . . , age 15 was admitted on January 10, 1973 following a transfer from the University of Pa. Hospital Psychiatric Unit. Please refer to the summary of his hospital admission for details of that admission and the reason regarding his transfer to our facility. On admission A . . . was cooperative, demonstrated slurred speech secondary to a great deal of over-medication. The medication was felt to be indicated in order to facilitate his transfer from the Hospital of the University of Pa. to Haverford State Hospital. At the time of admission A . . . was on Tofranil 50 mgm t.i.d., Thora ine 25 mgm t.i.d., Valium 5 mgm b.i.d., Tylenol 2 tablets q 4 hrs. prn headache. Following a review of the clinical material from the Hospital of the Uni- ersity of Pa. including a medical evaluation for Cushings Disease, it was our opinion that a further neurologic consultation was indicated. This was accomplished and at the time of this dictation it was the opinion of the consulting neurologist that there was no underlying neurological disease and A . . . problem was indeed primarily psychiatric. A psychological testing which was completed prior to the time of this dictation demonstrated a very limited capacity in many spheres including ego strength.

academic skills and overall personality development. Our goals relative to his education were therefore set with minimal demands and he was assigned to the small tutoring group rather than the day school. Gradually all medication was discontinued and he was then placed on a small amount of Stelazine at bedtime along with Cogentin and was given prn analgesics for a continued complaint of tension headaches. The plan during the hospital stay was to facilitate his return to his family and to complete his full year with the Haverford Day School Staff.

DIAGNOSIS:

Adjustment reaction of adolescence with depressive features and intellectual limitations and poor impulse control.

(s) G.B. Kratsa
Gus Kratsa, M.D.

GK/dmn.

OPINION—JULY 24, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.

Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

HUYETT, J., July 24, 1975:

OPINION AND ORDER

Plaintiffs have filed this class action[1] on behalf of the named plaintiffs and all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the

[1] On April 29, 1974, we ordered that this action be maintained as a class action but left open the possibility that the definition of the class set out in the text might be amended or altered before the decision on the merits. We now find that this definition of the class is appropriate. We note that this action concerns children who allegedly are mentally ill as well as children who allegedly are mentally retarded.

Pennsylvania Mental Health and Mental Retardation Act (Act). 50 P.S. §§4402 and 4403 (§§402 and 403).[2]

[2] Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 provides in part:

Section 402. Voluntary admission; application, examination and acceptance; duration of admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of Section 402 (a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

Section 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 provides in part:

Section 403. Voluntary commitment; application, examination and acceptance; duration of commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) The application shall be in writing signed by the applicant in the presence of at least one witness. When an

Invoking 28 U.S.C. §§1331 and 1343(3) and 42 U.S.C. §1983, plaintiffs ask us to declare §§402 and 403 unconstitutional and enjoin their enforcement.[3]

Plaintiffs contend that in violation of the Fourteenth Amendment to the United States Constitution, they are being denied both due process of law and equal protection of law because Pennsylvania allows plaintiffs and their class to be detained—denied their liberty—in mental institutions without substantial procedural safeguards including the: (1) right to notice; (2) right to a pre-commitment hearing; (3) right to counsel and if indigent appointment of counsel; (4) right to present evidence on

application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

[3] Plaintiffs do not challenge either Section 405 or 406 of the Pennsylvania Mental Health and Mental Retardation Act of 1966. Section 405 permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than 10 days. Section 406 permits involuntary commitment of persons upon petition to the state court of common pleas and after hearing and examination. The person to be committed is entitled to notice of hearing, the right to counsel, and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

their own behalf; (5) right to subpoena witnesses and documents; (6) right to confront and cross-examine witnesses against them and those who wish to admit or commit them; (7) right to be involuntarily detained only upon a decision of a judicial officer; (8) right to be involuntarily detained only upon a decision that they are in need of treatment, care, or observation.[4] Plaintiffs also contend that the regulations supplementing §§402 and 403 do not cure these sections of their constitutional infirmities because they apply only to children 13 years of age or older, require no pre-commitment hearing, and designate no time by which a post-commitment hearing must be held.[5] In essence, plaintiffs claim that the present procedures do not adequately assure against the mistaken commitment of children who are not mentally ill.

[4] We are not presented with the issue of what standards are needed for commitment. For an analysis of this question see the recent opinion of J. Hoffman in *Commonwealth ex rel. Charles Finkin, Jr. v. Roop*, Pa. Superior Ct. (1975). Also see, *Bell v. Wayne County*, 384 F. Supp. 1085, 1095 (E.D. Mich. 1974).

[5] After plaintiffs filed this action the Department of Public Welfare, pursuant to Section 201(2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966, adopted additional procedural safe-guards for children admitted or committed to institutions pursuant to Sections 402 and 403. These regulations provide in part:

> 1. All juveniles age 18 and younger to be admitted to an Institution[6] must be referred from a recognized medical facility Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist;
>
> 2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;

> 3. The Director of the Institution or his delegate, shall have conducted an independent examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile;
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> 4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;
>
> 5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached);
>
> 6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director, or his delegate, shall notify the Public Defender's Office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two-day period, the juvenile shall remain institionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director, or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service Unit to

In support of their claim that §§402 and 403 are unconstitutional, plaintiffs have submitted brief summaries of the reasons for the commitment of the named plaintiffs and other members of their class to demonstrate that many decisions to commit involve factual determinations requiring substantial procedures to guard against wrongful or erroneous commitment. We rely for our findings on the summaries contained in the final pretrial order which have been stipulated to and on defendants' exhibit numbered eight (8).

The named plaintiffs were either admitted under §402 or committed under §403 to Haverford State Hospital.[6] Plaintiff M.W. was admitted to Haverford State

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file a 406 proceeding within two days after failure to locate the applicant;

7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile;

8. If the staff member of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification;

The regulations do not provide a time by which a commitment hearing must be held. The Attorney General of Pennsylvania assures us that in cases involving children at least 13 years of age, commitment hearings are scheduled within a short while after the child objects. With respect to children 12 years of age or younger, there is no requirement for a hearing, no less a designated time. Defendants submit that these regulations were not adopted with and towards this litigation and that with or without them, Sections 402 and 403 are constitutional.

[6] By stipulation Haverford State Hospital was withdrawn as a defendant. Haverford is a mental health "facility" under Section 102 P.S. §4102 of the Mental Health and Mental Retardation Act. It receives admissions and commitments of persons including persons eighteen years of age or younger admitted or committed under Sections 402 and 403.

Hospital under §402(a)(2). His mother admitted him allegedly against his wishes when he was fifteen and on December 1, 1972, he informed agents and employees of defendant of his desire to leave Haverford State Hospital. Plaintiffs K.B., S.G., L.L., and V.M. were committed to Haverford State Hospital under §403(a)(2). Plaintiff K.B. was fifteen when his mother committed him against his wishes. He was and still is critical of some of the hospital's regulations and treatment practices. Plaintiff S.G. was seventeen when his father committed him allegedly against his wishes. Plaintiff L.L. was fifteen when her mother committed her allegedly against her wishes. Her difficulties in relating to her mother resulted in her commitment. Hospital records show that she threatened the lives of her mother and sister and that she has a personality disorder. Her parents are divorced and her father is remarried, living in Florida. At the time of her commitment and the time this action was filed, she would have preferred to have been with her father and when she is with him her behavior is excellent. Plaintiff V.M. was fourteen when her mother committed her allegedly against her wishes.

Members of plaintiffs' class have been institutionalized for various other reasons. Patient number 13,173, a moderately retarded 13 year old child, was institutionalized in Polk State Hospital because of very sudden, explosive, rage reactions during which he attacked others and of which he has no recollection. His behavior rather than his mental retardation was the primary obstacle to his return to the community. Patient number 13,212, an

educable mongoloid boy with the capacity to participate in many educable and trainable activities and who can be helped by an active special elementary program in public schools, was institutionalized in Polk State Hospital for a 1 to 2 week period so that the other members of his family could go on a family vacation. Patient number 288, a mentally retarded child, was placed in Western State Hospital because of a poor family situation. The mother of the child did not get along well with the child, and the family was afraid that she would have another nervous breakdown if the child were not placed in Western State Hospital. Patient number 281, a mentally retarded child, was placed in a state institution because she had become a management problem to both her parents and the community. Patient number 15, a mentally retarded child, was placed in Western State Hospital because the child interfered with the routine of the household and disturbed family members. The placement was based on a fear that if the child remained in his home, the mother might break down, the marriage of the child's parents might end in separation, the father's health might fail, and an adolescent daughter might be pushed into a premature marriage to escape an unhappy home. Class members have also been committed to mental hospitals for running away, robbing a gas station, stealing in general, chasing and striking a girl, arson, delinquent behavior in general, truancy, physical ailments such as colitis and weight loss, school phobia, and drug overdose.

At the time this action was filed defendants were all Pennsylvania officials with specific duties under the Act. Defendant Jack B. Kremens as Hospital Director of Haverford State Hospital was charged under 50 P.S. §§4102 and 4203 with supervision and administration of Haver-

ford State Hospital. It was to Kremens or his delegates that application for admission and commitment under §§402(b) and 403(b) of the Act had to be made. Defendant Helene Wohlgemuth as Secretary of Public Welfare of the Commonwealth of Pennsylvania (Secretary) had the power under 50 P.S. §§4201 and 4202(a) to enforce the Act, to make all regulations necessary and appropriate to the proper accomplishment of the Act, and to operate and assign functions to all state facilities. Defendant William B. Beach as the Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania had the general authority to supervise and regulate mental Health facilities in Pennsylvania.

At the outset, defendants contend that since the purpose of the Act is to meet the child's needs through treatment and rehabilitation rather than to punish the child by incarceration for what he has done, the requirements of due process do not apply to the institutionalizing of children under §§402 and 403.[7] Defendants proceed to argue

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[7] A number of defendants in similar cases have raised this argument. In *In re Gault*, 387 U.S. 1, 21 (1966), defendants claimed that juveniles obtain benefits from the informal juvenile procedures which more than offset the disadvantages of denying them the substance of normal due process. The Court rejected this argument holding:

> observance of due process standards, intelligently and not ruthlessly administered, will not compel the States to abandon or displace any of the substantive benefits of the juvenile process.

In *Denton v. Commonwealth*, 383 S.W. 2d 681 (Ky. 1964), cited approvingly by Judge Biggs in *Dixon v. Attorney General of Pennsylvania*, 325 F. Supp. 966, 972 (M.D. Pa. 1971), the court also rejected this argument holding that commitment procedures should

that if we determine that due process applies, we should find that in light of Pennsylvania's interest in protecting the child, preserving the family unit, maintaining the rights of parents to the custody, care, and upbringing of their children, and protecting society, the present statutes and

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be the same in civil commitment proceedings as they are in criminal proceedings. Responding to this same argument, Judge Biggs in *Dixon* stated: "We are unimpressed by the parens patriae argument and strong courts have not been persuaded by it." (Citations omitted.) In *Holm v. State*, 404 P.2d 740, 742 (Wyo. 1965) the Wyoming Supreme Court held:

> No matter how commendable the motives back of legislation for the mentally ill may be it still remains the fundamental law of the land that a person is not to be deprived of his liberty—whether by involuntary hospitalization or some other kind of incarceration—without due process of law.

In *Heryford v. Parker*, 396 F.2d 393 (10 Cir. 1968), the court held that even if the institutionalizing of children is for rehabilitation, the constitutional safeguards of due process must be observed. The court in *Lessard v. Schmidt*, 349 F. Supp. 1078 (— Wis. 1972), was faced with the argument that due process procedures should be relaxed because of a subsequent right to treatment and because the commitment proceedings were civil in nature. After examining the effect civil commitment may have on those adjudged mentally ill, the court rejected these arguments and held that all persons 18 years of age or older being held pursuant to any emergency, temporary, or permanent commitment provision of the Wisconsin involuntary commitment statute, were entitled to substantial procedural safeguards. *Saville v. Treadway*, F. Supp. (M.D. Tenn. 1974) presented a challenge to a Tennessee Statute which permitted the "voluntary" commitment of juveniles by a parent, guardian, or person having legal custody of a mentally retarded minor. While recognizing the services furnished to mentally retarded children by the state, and the efforts in mental rehabilitation of the state, the court held that "where individual liberty is at stake . . . it is absolutely essential that such confinement be preceded by adequate procedural safeguards."

regulations satisfy any due process requirements. Finally, defendants argue that since under §§402 and 403 the parents, guardians ad litem, or persons standing in loco parentis must set into motion the commitment machinery, these persons effectively waive any due process rights of plaintiffs and their class.

DISCUSSION

Under the constitutional guarantee of procedural due process, we have developed a system whereby a person who may be subjected to a grievous loss of liberty is entitled to adequate procedural safeguards. *Wolff v. McDonnell*, 418 U.S. 539 (1974). Generally, the state is required to provide substantial procedures when there is the possibility of erroneously and wrongfully depriving persons of their liberty by committing them to mental institutions. See, concurring opinion of Chief Justice Burger in *O'Connor v. Donaldson*, 43 U.S.L.W. 4929, 4935 (1975); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard v. Schmidt*, 349 F. Supp. 1078, remanded 414 U.S. 473 (1974); redecided 379 F. Supp. 1376 (1974), remanded 43 U.S.L.W. 3600 (May 12, 1975); *Dixon v. Attorney General Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971). These safeguards attempt to protect persons from an arbitrary or erroneous deprivation of liberty or property, whether that deprivation be imposed for benevolent or punitive reasons. They are "our best instruments for the distillation and evaluation of essential facts from the conflicting welter of data that life and our adversary methods present." They "enhance the possibility that truth will emerge from the confrontations of opposing versions and

conflicting data." *In re Gault*, 387 U.S. 1, 21 (1966). As Mr. Justice Frankfurter has said: "The history of American freedom is, in no small measure, the history of procedure." *Malinski v. New York*, 324 U.S. 401, 414 (1945) (separate opinion) cited by the majority in *In re Gault*, at 21. If we are to preserve our traditional liberty we must scrutinize with care any claim that it is being arbitrarily denied.

In deciding whether the requirements of due process apply in any given case, the threshold question is whether the interest of the complaining party is within the contemplation of the liberty or property language of the Fourteenth Amendment. *Morrissey v. Brewer*, 408 U.S. 471, 481 (1971). The particular question here is whether or not a child's interest in not being institutionalized under §§402 and 403 is safeguarded by the Fourteenth Amendment. Defendants would have us find that because Pennsylvania is acting as parens patriae and not as an adversary, and because the admission and commitment proceedings are civil, not criminal, in nature, plaintiffs and their class may not complain of the deprivation of procedures available in criminal cases. Such a finding would ignore that the child is involuntarily removed from his home and familiar surroundings and is committed to an institution where "[he] suddenly faces the regimented routine of ward life and daily confrontation with state employees, however capable, rather than family and friends." *In re Ballay*, 482 F.2d 648, 669 (D.C. Cir. 1973). As the Court of Appeals for the Tenth Circuit noted in *Heryford v. Parker*, 396 F.2d 393, 396 (1968):

> It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is

> the likelihood of involuntary incarceration whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process.

Defendants' contention also ignores the stigma associated with civil commitment which some commentators and courts have noted may render civil commitment a more lasting abridgement of personal freedom than imprisonment for commission of a crime.[8] The child who faces

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[8] Loss of liberty is in issue not only when a person is physically confined. The Due Process Clause also affords protection "where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him." *Wisconsin v. Constantineau*, 400 U.S. 433, 437 (1971); *Board of Regents v. Roth*, 408 U.S. 564, 573 (1972); *Goss v. Lopes*, 419 U.S. 565 (1975); *Donalds v. O'Connor*, 493 F.2d 507, 520 (5 Cir. 1974), vacated and remanded *O'Connor v. Donaldson*, 43 U.S.L.W. 4929 (1975).

While we hope that society is moving in the direction of viewing mental illness in the same light as physical illness, we cannot ignore the reality that many in our society view mental illness with disdain or apprehension. See *In re Ballay*, 482 F.2d 648, 668 (D.C. Cir. 1973), where the court noted that, "[e]ven accepting recent medical advances, current studies clearly indicate the fallacy of contending that most people view mental illness as a disease similar to any physical ailment of the body" and that it could not "ignore the striking example of this attitude displayed by news stories and public reaction to disclosures made by a recent vice-presidential aspirant." In *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania*, 343 F. Supp. 279, 293 (E.D. Pa. 1972), Judge Masterson, writing for the three judge court, held that in light of *Wisconsin v. Constantineau, supra*, due process requires a hearing before retarded children may be denied a public education because of the stigma which our society unfortunately attaches to the label of mental retardation.

the possibility of being physically confined for an indeterminate period with all of the ramifications of such confinement clearly has an interest within the contemplation of the liberty and property language of the Fourteenth Amendment.

Having decided that due process applies, we are left with the questions of what process is due, *Morrissey v. Brewer, supra,* at 481 and whether this process may effectively be waived by plaintiffs' parents, guardians ad litem, or persons standing in loco parentis.[9] Before discussing the process here, we shall first consider whether or not parents, guardians ad litem, or persons standing in loco parentis may effectively waive the personal rights of children, since such a finding obviates the need to decide whether the present procedure violates the constitutional right of plaintiffs to procedural due process. The question is both difficult and unique. Viewing the issue as whether or not a parent may effectively waive personal rights of a child when the child objects to the waiver creates a confrontation between a liberty interest of plaintiffs we find constitutionally protected and the consistently recognized authority of parents to direct the rearing of their children. *Ginsberg v. New York,* 390 U.S. 629, 639 (1968).

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[9] As yet, the Supreme Court has not decided whether the child's parent, acting on behalf of the child, may effectively waive constitutional rights of the child. In *Heryford v. Parker, supra,* the court, in holding that the Due Process Clause applies to an involuntary civil commitment procedure, recognized that special problems may arise with respect to the effective waiver of rights by minors and mentally deficient persons. Finding that there was no express attempt to make such a waiver, the court did not decide the issue.

We presume that in most instances parents, proceeding in utmost good faith, acting for the child, in the child's best interests, properly guide, protect, and control their children. In *Wisconsin v. Yoder,* 406 U.S. 205, 231, 232 (1971), the Supreme Court, stating that it was not determining the proper reconciliation of possible competing interests of parents, children, and the state, noted that:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

Also, see, Justice Stewart's concurring opinion at 237. We are not unmindful of this tradition and its importance to the structure of our society, *Ginsberg* at 639, and if we could find that in all instances parents act in the best interest of their children, we might also find that parents may waive constitutional rights of their children. Unfortunately, as such a graphic example as parental child abuse illustrated,[10] this is not the case.[11] In deciding to

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[10] See Memorandum and Order of Judge Urbom filed June 4, 1974, in *Horacek, etc., v. Exon, et al.,* Civil Action No. 72-L-299 (D.C. Neb. 1974). The claim before Judge Urbom was that the named plaintiffs were in a state hospital because their parents put them there. Responding to the argument that plaintiffs were in the hospital voluntarily because their parents placed them there, Judge Urbom held that "parents cannot deprive their children of constitutional rights—rights of the children vis-a-vis the state."

[11] Dissenting in *Kent v. United States,* 401 F.2d 408, 416, n.4 (D.C. Cir. 1968), the now Chief Justice Burger noted:

> Lawmakers in recent years have been sensitive to the need to make civil commitment difficult recognizing the dan-

institutionalize their children, parents, as well as guardians ad litem or persons standing in loco parentis, may at times be acting against the interests of their children. With this in mind we must agree with Judge Judd in *New York State Association for Retarded Children*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973), that, "in the absence of evidence that the child's interests have been fully considered," parents may not effectively waive personal constitutional rights of their children.[12]

Remaining is the question of what process is due. Due process is flexible in that a determination of what process is due cannot be made without an evaluation of "the precise nature of the government function involved as well as of the private interest that has been affected by government action." *Cafeteria Workers Union v. McElroy*, 367 U.S. 886, 895 (1961). At a minimum, it requires that "deprivation of . . . liberty . . . by adjudication be

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gers of relatives "farming" out their kindred into mental institutions for motives not always worthy.

In *New York State Association for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973), the court stated:

> [t]here may be a fundamental conflict of interest between a parent who is ready to avoid the responsibility of caring for an abnormal child, and the best interests of the child. Murdock [Civil Rights of the Mentally Retarded: Some Critical Issues], 48 Notre Dame Lawyer at 139-143.

[12] This finding does not mean that when considering whether or not to institutionalize a child, the state should ignore the opinions and observations of the child's parents. Rather, the committing authorities should listen carefully to parents who live with and observe the child on a daily basis for they very likely have invaluable information concerning their child.

preceded by notice and opportunity for hearing appropriate to the nature of the case,"[13] but the formalities of the procedure however, "the timing and content of the notice and the nature of the hearing will depend on appropriate accommodation of the competing interests involved."[14] Because courts cannot determine what process is due without evaluating the competing interests, the content of due process shifts as the interests shift; "[t]he required degree of procedural safeguards varies directly with the importance of the private interest affected and the need for and usefulness of the particular safeguard in the given circumstances and inversely with the burden and any other adverse consequences of affording it."[15]

As previously discussed, plaintiffs' interest in being free from the wrongful and unwarranted deprivation of their liberty is substantial and they argue that the present procedure does not adequately protect this interest. The state's interests are three fold. It has an interest in the mental health of children (parens patriae), an interest in preserving the family unit and maintaining parental authority over children, and an interest in confining, for the protection of society those persons who pose significant danger to the community (police power). The state has decided that its interests require a relaxed, informal procedure, and it argues that a more formal procedure will substantially interfere with its interests. To strike a proper

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[13] *Goss v. Lopez*, 419 U.S. 565, 79 (1975), citing *Mullane v. Central Hanover Trust Co.*, 339 U.S. 306, 313 (1950).

[14] *Goss v. Lopez*, at 579, citing *Cafeteria Workers v. McElroy*, 367 U.S. 886, 895 (1961); *Morrissey v. Brewer, supra*, at 481.

[15] See, Friendly, J. "Some Kind of Hearing", 123 U. Pa. L. Rev. 1267, 1278 (1975).

balance between the competing interests of plaintiffs and the state, we shall analyze them in the context of each procedural right of which plaintiffs claim they are being deprived. This will give us the content of the process which, at a minimum, is due before plaintiffs may be institutionalized for treatment.[16]

PRE-COMMITMENT HEARING

A decision to institutionalize a child is often a difficult yet necessary decision for a child's parent to make. It is generally pursued only after all other alternatives have proven futile. The state has an interest in seeing that a procedural system will not deter parents, already faced with this difficult decision, from attempting to institutionalize children who are in need of treatment only mental institutions can provide. Further, to protect society and the individual child, the state has an interest in the immediate detention of children who may be dangerous

[16] As we have already noted, due process is flexible; the Constitution mandates no specific code of procedures. We are aware of the problems facing courts when they attempt to fashion procedures protecting interests within the liberty and property language of the Fourteenth Amendment and we are sensitive to the claim that courts are "good at deciding cases, bad at drafting legislation. . . ." See, Friendly, J. "Some Kind of Hearing", supra. When presented with claims of constitutional dimension, however, we are constrained, when legislative bodies have failed to act, to find means of enforcing the constitutional rights being denied. Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are as fully effective as those which we set out. See *Miranda v. Arizona*, 384 U.S. 436, 490 (1966); *Morrissey*, at 490.

to themselves or others. See, *Lessard v. Schmidt*, at 1092; Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1275 (1974).

Balancing these substantial interests of the state with that of the child, we find that plaintiffs are not entitled to a pre-commitment hearing. As the Supreme Court has found with criminal cases, however, we find that, for the protection of the child, he is entitled to a hearing before an unbiased tribunal within a reasonable time to test whether there is probable cause to believe institutionalization is necessary. *McNabb v. United States*, 318 U.S. 332, 343-344 (1943); *Morrissey v. Brewer*, at 489 (1971); *Lynch v. Baxley*, at 388. In no event shall detention of the child in the absence of a probable cause hearing exceed seventy-two (72) hours from the date of the initial detention. See, *Lynch v. Baxley*, at 388; *Lessard v. Schmidt*, at 1091.[17]

POST-COMMITMENT HEARING

If the conclusion of the preliminary hearing is that there is probable cause for believing the child needs institutionalization, the child is entitled to a post-commitment hearing before an unbiased tribunal on the need for commitment. A delay after the probable cause hearing is permissible. This delay will allow the child to adjust

[17] In *Lynch v. Baxley*, at 388, the court held that emergency detention without a hearing on its appropriateness may not, in the absence of a probable cause hearing, exceed seven (7) days from the date of the initial detention. In *Lessard v. Schmidt*, at 1091, the court held that a probable cause hearing must be held within forty-eight (48) hours from the date of the initial detention.

to his new surroundings and will allow both the state and the child time to prepare for the post-commitment hearing to come. It will also allow the state time to examine and diagnose the child adequately. These reasons do not, however, justify a prolonged period of confinement without a final determination on the need for institutionalization and should not exceed a two-week period. A two-week period will afford all parties an opportunity to prepare adequately and properly their positions with hope of ascertaining that which is best for the child.[18]

NOTICE

The opportunity to be heard is fundamental to due process of law. *Grannis v. Ordean*, 234 U.S. 385, 394 (1914). Without notice of that which is to transpire at a hearing "sufficiently in advance of any required hearings so that reasonable opportunities to prepare will be afforded," *In re Gault*, at 33; *Lessard v. Schmidt*, at 1092; *Lynch v. Baxley*, at 388, the right to be heard has little significance. *Mullane v. Central Hanover Tr. Co.*, at 314. To counterbalance this substantial interests of plaintiffs the state argues that by delaying treatment and traumatizing the child, the requirement of notice will aggravate the child's mental illness, interfere with the state's police power, and disrupt family harmony. In *Gault* at 21, the Supreme Court refused to accept the state's fear of trauma

[18] Until the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearings the present facilities of the Commonwealth court system shall be used for these hearings.

as a justification for limited procedures. The Court stated that the observance of due process standards will not necessarily compel the states to abandon the substantive benefits of the juvenile process. Further, as Judge Tamm noted in *In re Ballay*, 482 F.2d 648, 664 (D.C. Cir. 1973), the fear that added procedural requirements will produce trauma presupposes that the person who faces commitment is mentally ill. Likewise, while procedural safeguards assume that not all persons who face commitment need actually be committed, the argument that procedures will interfere with the state's police power and disrupt family harmony assumes that the child is dangerous to others and comes from a family in harmony.

Keeping in mind that due process assures against error, we find written notice required, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment. See, *Lynch v. Baxley*, at 388; *Lessard v. Schmidt*, at 1092. Neither the state nor plaintiffs have an interest in committing to mental institutions children not in need of institutionalization. Notice should not shield children in need of institutionalization from commitment and treatment but rather should protect children not in need of institutionalization from wrongful commitment and improper deprivation of their liberty.[19]

[19] Obviously this notice may be meaningless to some children. We, therefore, find that until some other procedure is established this notice shall be sent not only to the child but also to the Clerk of the Court with jurisdiction and shall be forwarded to the child's attorney. The child's attorney shall be in receipt of the notice at least forty-eight (48) hours prior to the initial hearing.

COUNSEL

The state fears that assistance of counsel will make institutionalization proceedings adversarial adding to the delay in treatment of the child and increasing the danger of trauma already inflicted by notice and a hearing. Yet the spectre of this particular trauma pales beside the spectre of the trauma inflicted on a child erroneously committed.[20] Notice and the opportunity to be heard may be of little value without the assistance of counsel. *Argesinger v. Hamlin,* 407 U.S. 25, 31 (1972); *Powell v. Alabama,* 287 U.S. 45, 68-69 (1932). A child whose liberty is in question "needs the assistance of counsel to cope with problems of law, to make skilled inquiry into the facts, to insist upon regularity of the proceedings, and to ascertain whether he has a defense and to prepare and submit it." *Gault,* at 36. As the right to counsel applies to

[20] The possibility and danger of error is discussed by D. L. Rosenhan in "On Being Sane in Insane Places," 179 Science 250 (1973). The article describes an experiment in which eight sane persons gained admission to twelve different hospitals and behaved normally. Their sanity was never discovered. Not only was their sanity not detected, but the psychodiagnostic label placed on the individual patients was never removed. According to Professor Rosenhan this error apparently resulted from what statisticians call type two error—error resulting from a Doctor's inclination to call a healthy person sick rather than a sick person healthy because it is more dangerous to misdiagnose illness than health.

Rosenhan suggests that the initial labelings color others' perception of the patient and eventually the patient himself accepts the diagnosis, with all of its connotations and expectations, and behaves accordingly. He also notes that there is substantial evidence that attitudes towards the mentally ill are characterized by fear, hostility, aloofness, and dread.

criminal cases, so it must apply during all significant stages of the commitment process, and plaintiffs must be informed of both their right to counsel and if indigent their right to appointment of free counsel. See, *In re Gault,* at 41; *Heryford v. Parker,* at 397; *Dixon v. Attorney General,* at 966; *Lessard v. Schmidt,* at 1097; *Lynch v. Baxley,* at 389; *United States v. Wade,* 388 U.S. 218, 226-27 (1967); *In re Barnard,* 455 F.2d 1370, 1375-76 (D.C. Cir. 1971); *Sarzan v. Gaughan,* 489 F.2d 1076, 1083-84 (1 Cir. 1973).

PRESENCE OF PERSON

In *Specht v. United States,* 386 U.S. 605, 610 (1967), the Supreme Court held that commitment proceedings under the Colorado Sex Offenders Act, whether denominated civil or criminal, are subject to the Due Process Clause of the Fourteenth Amendment and that due process requires that the person to be committed "be present with counsel, have an opportunity to be heard, be confronted with witnesses against him, have the right to cross-examine, and to offer evidence of his own." Also see, *Lynch v. Baxley,* at 394. In *Illinois v. Allen,* 397 U.S. 337, 342 (1969) the Court, rejecting the argument that the right to be present is absolute, held that the right of personally confronting witnesses may be lost by consent or at times even misconduct. Expanding this holding the *Lynch v. Baxley* court held that the right to be present may be knowingly and intelligently waived by persons faced with involuntary commitment or by adversary counsel acting in their behalf. This procedure protects such persons' constitutional right to be present and to assist in protecting their interests, yet it recognizes that situations exist where the

absence of such persons from commitment proceedings may serve their own best interests.

We adopt the *Lynch v. Baxley* procedure as appropriate for plaintiffs. Accordingly, we find that a child has a constitutional right to be present at all hearings concerning his proposed commitment. See, *McKiever v. Pennsylvania*, 403 U.S. 528, 543 (1971). This right may be waived by the child, however, and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. This right may also be waived by the child's attorney, and the unbiased tribunal may accept the waiver upon a finding that the child is too ill to attend the proceedings. See, *Lynch v. Baxley*, at 394.

RIGHT TO JURY TRIAL

The Supreme Court in *McKiever v. Pennsylvania, supra*, noting that conscientious judges are able fact finders, held that while fundamental fairness requires notice, the rights to counsel, confrontation, and cross-examination, and notice of standard of proof, it does not require jury trials. We agree.

STANDARD OF PROOF

That the fact finder may commit error is a risk of any litigation. *Speiser v. Randall*, 357 U.S. 513, 525-26 (1958). The standard of proof affects this risk for it instructs the fact finder on the degree of confidence society expects him to have in the correctness of his findings. See

Mr. Justice Harlan concurring in *In re Winship*, 397 U.S. 358, 370-71 (1969). In *Winship*, Justice Harlan suggests that setting the standard of proof for a particular category of adjudication reflects an assessment of the comparative social costs of erroneous factual determinations. He views the decision to apply a preponderance standard to suits between private parties for money damages as a decision that an erroneous verdict is no more serious for one party than for the other. He finds the standard of proof beyond a reasonable doubt required in the institutionalization of a child for delinquency because the social disutility of committing an innocent child—subjecting him to a complete loss of his personal liberty—outweighs the social disutility of committing error in his favor.[21]

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[21] Mr. Justice Harlan recognizes that in a judicial proceeding in which there is a dispute about the facts, all the fact finder can acquire is a belief of what probably happened. Mr. Justice White in *Goss v. Lopez*, 419 U.S. 565, 580 (1975) also recognized the possibilities of error when he noted that:

> Disciplinarians, although proceeding in utmost good faith, frequently act on the reports and advice of others; and the controlling facts and the nature of the conduct under challenge are often disputed. The risk of error is not at all trivial, and it should be guarded against if that may be done without prohibitive cost or interference with the educational process.

In discussing the possibilities of erroneous psychiatric diagnoses Rosenhan, in "On Being Sane in Insane Places," *supra*, raises several poignant questions which illustrate some of the problems in this area including:

> How many people, one wonders, are sane but not recognized as such in our psychiatric institutions? How many have been needlessly stripped of their privileges of citizenship, from the right to vote and drive to that of handling their own accounts? How many have feigned insanity in order to avoid the criminal consequences of their behavior, and, conversely,

Following this analysis, balancing the impact of an erroneous decision to commit a person with an erroneous decision to release a person, and taking into consideration the nature of the proceedings, the *Lynch v. Baxley* court held:

> Because the stigmatization and loss of liberty attendant upon forced confinement are of the most profound consequence to the individual affected, due process demands that he be subjected to such disabilities only if the necessity for his commitment is proved by evidence having the highest degree of certitude reasonably attainable in view of the nature of the matter at issue. In a civil commitment proceeding, the questions involved are the primarily subjective ones of the subject's mental condition and the likelihood that he will be dangerous in the future. Such subjective determinations cannot ordinarily be made with the same degree of certainty that might be achieved where purely objective facts and occurrences are at issue. Consequently, the trier of fact must be persuaded by clear, unequivocal, and convincing evidence that the subject of the hearing is in need of confinement under the minimum standards for commitment herein enumerated.

how many would rather stand trial than live indeterminably in a psychiatric hospital—but are wrongly thought to be mentally ill? How many have been stigmatized by well-intentioned but nevertheless erroneous diagnoses? On the last point recall again that a "type 2 error" in psychiatric diagnosis does not have the same consequences it does in medical diagnosis. A diagnosis of cancer that has been found to be in error is cause for celebration. But psychiatric diagnoses are rarely found to be in error. The label sticks, a mark of inadequacy forever.

These problems are similar to the problems discussed by Mr. Justice Harlan in *Winship* and Mr. Justice White in *Goss v. Lopez.*

We agree with this holding and find that the fact finder, in a hearing on commitment of a child, must apply the standard of clear and convincing proof as opposed to the standards of beyond a reasonable doubt and preponderance of the evidence. Applying a preponderance standard creates too great a risk of erroneous commitment, wrongfully depriving a child of his interest in liberty, and interest of "transcending value,"[22] and, given the subjectivity and "relatively undeveloped state of psychiatry as a predictive science,"[23] requiring proof beyond a reasonable doubt creates too great a risk of erroneously releasing children in need of institutionalization.

RIGHTS AT THE COMMITMENT HEARING

Due process requires that before a decision to commit, an adult be given the opportunity to confront and to cross-examine witnesses against him, *Specht v. Patterson,* 386 U.S. at 610; *Lynch v. Baxley* at 394, offer evidence in his own behalf, *Specht v. Patterson* at 610, and offer testimony of witnesses, *Lynch v. Baxley* at 394, citing *White v. Texas,* 388 U.S. 14, 19 (1967).[24] While formalizing commitment procedures, these rights do not require the

[22] *Speiser v. Randall,* 357 U.S. 513, 525 (1958).

[23] Note, Developments in the Law, Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1302 (1974).

[24] In *Morrissey v. Brewer, supra,* the Supreme Court held that due process requires certain minimum procedures before parole can finally be revoked. These procedures include the opportunity to be heard in person and to present witnesses and documentary

state to abandon the substantive benefits it presently hopes to achieve through treatment and rehabilitation. We commend the steps the state has taken in the interest of the mental health of children in need of institutionalization but, because of the tremendous personal as well as societal loss error might cause, we find that in addition to the rights previously discussed, the rights to confront and to cross-examine witnesses against him, to offer evidence in his own behalf and to offer testimony of witnesses are required before a decision to commit a child is made.[25]

To summarize, then, we have found that before they may be institutionalized plaintiffs and others of their class are entitled to (1) a probable cause hearing within seventy-two (72) hours from the date of their initial detention; (2) a post-commitment hearing within two (2) weeks

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evidence, and the right to confront and cross-examine adverse witnesses (unless the hearing officer specifically finds good cause for not allowing confrontation). Noting that these procedures are essential in criminal trials, where a person may be subjected to the most serious deprivation, and cases where a person may lose his job in society, the Supreme Court in *Wolff, supra,* held that because of the unique problems of penal institutions the determination of whether prisoners are entitled to these rights is best left to the discretion of the officials of the prisons.

[25] In support of their position plaintiffs submitted memoranda of law outlining the substantial procedural safeguards which they contend they are being denied. They briefly mention the contention that plaintiffs should have the right to remain silent. Against this claim we must balance the practical problems plaintiffs' silence may have on psychiatric evaluation almost always needed before plaintiffs may be institutionalized. In view of these potential problems and the limited discussion of the issue in this case we think that it would be inappropriate to decide this issue at this time.

from the date of their initial detention; (3) written notice, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment; (4) counsel at all significant stages of the commitment process and if indigent the right to appointment of free counsel; (5) be present at all hearings concerning their proposed commitment; (6) a finding by clear and convincing proof that they are in need of institutionalization; (7) the rights to confront and to cross-examine witnesses against them, to offer evidence in their own behalf, and to offer testimony of witnesses.[26] Accordingly, we declare the pertinent portions of Sections 402 and 403 unconstitutional on their face and as they apply to plaintiffs and others of their class, and we enjoin the enforcement of such portions.[27]

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[26] We neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made. As we found with respect to the right of the child to be present at all hearings concerning his proposed commitment, we find that, excepting the right to notice and counsel, any or all of these rights may be waived by the child and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights may also be waived by the child's attorney and the unbiased tribunal may accept the waiver upon a finding that the waiver is appropriate.

[27] Some courts have approached claims by children of constitutional deprivation by comparing the rights afforded adults with the rights afforded children and questioning whether there is a peculiar state interest justifying any disparity between them. See *State v. Koome,* 530 P.2d 260 (Wash. 1975). Authority for such an approach can be gleaned from the Supreme Court's statement in *In re Gault,* at 29, that "So wide a gulf between the State's

The foregoing is deemed to constitute findings of fact and conclusions of law as required by F.R. Civ. P. 52(a).

(s) John J. Gibbons,
John J. Gibbons, *C. J.*

(s) Daniel H. Huyett, 3rd,
Daniel H. Huyett, 3rd, *D. J.*

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treatment of the adult and of the child requires a bridge sturdier than mere verbiage, and reasons more persuasive than cliche can provide." Since we dispose of this case under the Due Process Clause we have no occasion to address the equal protection arguments directed at the disparate treatment of children and adults.

Plaintiffs also claim they are being denied equal protection of the law since persons above the age of eighteen (18) may voluntarily admit or commit themselves to mental institutions and persons eighteen (18) years of age or younger may not. Plaintiffs, however, failed to allege that any of the named plaintiffs ever attempted voluntarily to admit or commit themselves or even that they wish to. Accordingly, we find that plaintiffs lack standing to present this claim.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.

ORDER

NOW, July 24, 1975, IT IS ORDERED that judgment is entered in favor of plaintiffs and against defendants. Counsel for the parties shall confer and submit an appropriate form of Order consistent with this Opinion within twenty (20) days.

(s) John J. Gibbons,
John J. Gibbons, *C. J.*

(s) Daniel H. Huyett, 3rd,
Daniel H. Huyett, 3rd, *D. J.*

Re: Kevin Bartley, et al. v. Jack B. Kremens, et al. Civil Action No. 72-2272

BRODERICK, D.J., *dissenting.*

It appears to me that the majority opinion has prescribed "an overdose" of due process which could prove fatal to the voluntary commitment of children for in-patient treatment for mental or emotional disorders. The majority opinion declares unconstitutional §§402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act which provides that parents may make application for voluntary admission and commitment of their child age 18 or younger to a facility for examination, treatment and care. The due process procedure prescribed by the majority opinion for all voluntary admissions and commitments of juveniles 18 years of age and younger is as follows: (1) a probable cause hearing within 72 hours from the time of their initial detention; (2) a post- commitment hearing within 2 weeks of their initial detention; (3) written notice to the child stating the time and place of the hearing and the grounds for the proposed commitment. The notice must also be sent to the child's attorney; (4) counsel at all significant stages of the commitment process and, if indigent, the right to the appointment of free counsel; (5) the right of the child to be present at all hearings concerning his proposed commitment; (6) a finding, by "clear and convincing proof", that the child is in need of institutionalization; and (7) the right to confront and to cross-examine witnesses, and to offer evidence on his own behalf.

The Pennsylvania Mental Health and Mental Retardation Act and the regulations promulgated thereunder

provide for the voluntary admission[1] or commitment[2] of persons eighteen years of age or younger by a parent, guardian or individual standing in loco parentis to the person to be admitted. It is this voluntary admission or commitment procedure which the majority has declared unconstitutional. In effect, the majority has declared that no voluntary commitment of children by their parents can meet the constitutional requirements of the Fourteenth Amendment.

Under the Pennsylvania Act and regulations, application for voluntary admission or commitment[3] to a facility may be made by a parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years or younger.[4] In order to be admitted or committed to an institution, any person aged 18 and younger must first be referred from a recognized medical facility. Mental Health/Mental Retardation therapist or Mental Health Agency. Such referral must be accomplished by a psychiatric evaluation and a report which states with specificity the reasons that the child requires institutional care. After such referral, the director of the facility to which the parents seek to have their child ad-

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[1] 50 P.S. §4402(a)(2).

[2] 50 P.S. §4403(a)(2).

[3] The legislature chose to pass two distinct statutes, one of which deals with voluntary admissions to a facility while the other is concerned with voluntary commitments. Apparently, the main distinction in the two statutes is that under the later section dealing with voluntary commitments, the initial commitment is for a period not to exceed thirty days, with successive periods not to exceed thirty days each, so long as care or observation is necessary. The section providing for voluntary admissions contains no corresponding time limitation following admission to a facility.

[4] 50 P.S. §4402(a)(2); 50 P.S. §4403(a)(2).

mitted must then conduct an independent examination of the child in order to determine whether the child is in need of institutional care or observation. If the director's independent examination disagrees with the referring professional's opinion, the child cannot be institutionalized. In the case of a voluntary commitment under §403 of the Act, an acceptance for commitment may not exceed thirty days without a successive application for continued voluntary commitment for an additional thirty day period.[6] In the case of juveniles 13 years of age and older, within 24 hours of admission to the institution, the juvenile must be given written notification which he signs and which is to be fully explained to him and which states that he will be furnished with counsel to represent him. Should a juvenile who is 13 years of age or older object, either orally or in writing, to remaining in the institution, the director, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days, during which time notification shall be made to the applicant and the referral unit so that either party may institute a §406 proceeding, which is the statutorily required court hearing for an involuntary commitment. During that same two day period, the director must obtain counsel to represent the juvenile. The juvenile's counsel is then furnished with the evaluation of the juvenile by the referral unit, a psychiatric evaluation from the institution, and a written report of the reasons that the institution feels that institutionalization is required.[7]

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[5] 50 P.S. §4402(b); 50 P.S. §4403(b). [No corresponding text citation.]

[6] 50 P.S. §4403(b).

[7] I agree with the majority that these regulations which provide for instituting a §406 hearing do not provide for a period within which such a hearing shall be held following the objection of the child to remaining in the institution.

The effect of the Act and the regulations promulgated thereunder is that two independent medical opinions must concur in a recommendation of institutionalization before a minor can be voluntarily admitted. In the case of juveniles 13 and over, upon their objection to remaining in the institution, future institutionalization must proceed pursuant to the civil court commitment provisions of the Act (Section 406). Section 406 provides the procedure for an involuntary civil court commitment and requires the filing of a petition with the Court of Common Pleas, pursuant to which the Court issues a warrant requiring the allegedly ill person to be brought to Court for a hearing. Counsel appointed for the juvenile represents him at the hearing before the Court of Common Pleas. After the hearing, the Court may order an examination by two physicians or order commitment for a period not to exceed ten days for an examination, after which commitment may be ordered by the Court. Plaintiffs do not attack the constitutionality of the civil court commitments under §406 of the Act which follow the above outlined procedure.

I do not take the position that children have no rights. I simply feel that the procedures outlined by the Pennsylvania Legislature, when balanced against the traditional rights of parents to control the rearing of their children, afford sufficient protection to the child. The present Act does not permit a parent who seeks to admit a child under §402 or §403 to simply hand over the child to the institution. Two psychiatrists must agree, after an examination, that the child is in need of institutionalization. In the case of a voluntary commitment, a periodic review

must be performed by the director every thirty days to determine whether continued institutionalization is necessary. And in the case of a juvenile thirteen years of age and older, the juvenile is entitled to a hearing with counsel concerning his need for institutionalization following his objection. The majority in this case holds that all children are constitutionally entitled to a similar type of hearing within two weeks of their institutionalization. The only group for which the present regulations have not provided a hearing subsequent to their being received in the institution are those children 12 years of age and under. Because of this alleged defect, the majority declares §402 and §403 unconstitutional.

It is now a well settled principle that "due process 'is an elusive concept', the content of which 'varies according to specific factual contexts.'" *Hannah v. Larche*, 363 U.S. 420, 442 (1960); *Logan v. Arafeh*, 346 F. Supp. 1265, 1268 (D. Conn. 1972).

> [C]onsideration for which procedures due process may require under any given set of circumstances must begin with a determination of the precise nature of the government function involved as well as the private interest that has been affected by government action. *Cafeteria and Restaurant Workers Union, Local 473, AFL-CIO v. McElroy*, 367 U.S. 886, 895 (1961).

Due process of law does not require a hearing in every conceivable case of government impairment of private interest. *Stanley v. Illinois*, 405 U.S. 695 (1972).

An evaluation of the competing interest involved in this case leads me to the conclusion that §402 and §403 of the Act and the regulations thereunder are constitutional

on their face. Without minimizing the interest of a child 12 years and under to be free from a wrongful and unwarranted deprivation of his liberty, the traditional interest of the state in preserving the family unit and in maintaining parental control over their young children is such that the strict procedural due process requirements imposed by the majority holding as to "voluntary" commitments are not required by the Fourteenth Amendment.

The Supreme Court has repeatedly recognized and afforded great weight to the rights of parental control and custody of their children and has given due respect to the powerful role of the familial relationship in our democratic society. This substantial interest of parents undeniably warrants deference and, absent a powerful countervailing interest, warrants protection. It is plain that the interest of family integrity and the interests of parents in the care, custody and nurture of their children come to the court with a momentum deserving of respect. *Kovacs v. Cooper*, 336 U.S. 77, 95 (1949) (Frankfurter, J., concurring).

As the Supreme Court stated in *Stanley v. Illinois*, 405 U.S. 645, 651 (1972):

> The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed "essential," Meyer v. Nebraska, 262 U.S. 390, 399, 43 S.Ct. 625, 626, 67 L.Ed. 1042 (1923), "basic civil rights of man," Skinner v. Oklahoma, 316 U.S. 535, 541, 62 S.Ct. 1110, 1113, 86 L.Ed. 1655 (1942), and "[r]ights far more previous . . . than property rights," May v. Anderson, 345 U.S. 528, 533, 73 S.Ct. 840, 843, 97 L.Ed. 1221 (1953). "It is cardinal with

> us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." Prince v. Massachusetts, 321 U.S. 158, 166, 64 S.Ct. 438, 442, 88 L.Ed. 645 (1944). The integrity of the family unit has found protection in the Due Process Clause of the Fourteenth Amendment, Meyer v. Nebraska, *supra,* 262 U.S. at 399, 43 S.Ct. at 626, the Equal Protection Clause of the Fourteenth Amendment, Skinner v. Oklahoma, *supra,* 316 U.S., at 541, 62 S.Ct. at 1113, and the Ninth Amendment, Griswold v. Connecticut, 381 U.S. 479, 496, 85 S.Ct. 1678, 14 L.Ed. 2d 510 (1965) (Goldberg, J., concurring).

The authorities cited above make it clear that the parents' interest in directing the upbringing of their children is cognizable and substantial. *Stanley, supra* at 652. Those who nurture the child and direct his destiny have the right coupled with the high duty, to recognize and prepare him for additional obligations. *Pierce v. Society of the Sisters of the Holy Names, etc.,* 268 U.S. 510, 535 (1925). The parents' claim to authority in their own household to direct the rearing of their children has been termed "basic to the structure of our society." *Ginsberg v. State of New York,* 390 U.S. 629, 639 (1968). In *Wisconsin v. Yoder,* 406 U.S. 205 (1972), the Supreme Court stated at 232:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

As Chief Judge Bazelon of the District of Columbia Court of Appeals has stated:

> [T]he family is the most effective child-developing agent around, when it wants to be and can be. Out of the plethora of studies of day care and early intervention, one thing stands out: a child needs most a family—it is there that he finds his roots and his education. Mothers and fathers who spend time with their child are better at it than are most organized group care arrangements. David L. Bazelon, *Whose Needy Children?* University of Michigan Journal of Law Reform, vol. 8, 247.

Simply stated, it is my opinion that the present Act and the regulations thereunder which require two independent psychiatric evaluations recommending institutionalization before a parent can voluntarily have his child admitted for treatment or observation provides sufficient protection to the child against an unwarranted or unjustified institutionalization.

The record in this case demonstrates that most parents act in the best interests of their child when making the decision to voluntarily submit their child to institutional treatment. Indeed, those parents whose motives the majority opinion questions are few and far between. Children of the age of twelve and younger are at a stage of development when parents must have direct control over their care and treatment. Parents of such young children are best able to make a determination as to their child's needs, and their decision to seek institutional care and treatment for their child comes only after all other alternatives for treatment and care have been exhausted. To protect a child from being institutionalized when not in need

of such care, the State has developed a system whereby the independent judgment of two experts, trained in this difficult area, must concur with the parents' decision.[8]

As the record in this case clearly reveals, the modern trend in the treatment of the mentally and emotionally ill and the retarded is to institutionalize for the least amount of time and only when all else has failed. The majority opinion expressed concern as to the warehousing of children which might result from the voluntary commitment procedure. However, since the recent opinion of the Supreme Court in *O'Conner v. Donaldson*, 43 U.S.L.W. 49-29 (1975), this fear should be dissipated by the Court's holding that a state cannot constitutionally confine a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. I find that the procedures set forth by the majority which require two hearings with counsel appointed for the child, the confrontation and cross-examination of parents and the requirement of clear and convincing proof of the need of institutional care needlessly destroys the voluntary commitment procedure without affording any significant protection for the child. The adversary nature of the procedure which the majority requires will significantly increase the trauma which accompanies the institutionalization of sick chil-

[8] I am aware that courts in Nebraska and Tennessee have declared unconstitutional statutes which permit the voluntary institutionalization of children. *Horacek, etc. v. Exon, et al.*, Civil Action No. 74-L-299 (D.C. Neb. 1974). *Saville v. Treadway*, Civil Action No. 6969 (M.D. Tenn. 1974). However, it is not apparent from reading the opinions in those cases whether both Nebraska and Tennessee provide a protective procedure similar to those provided for under the Pennsylvania statute and regulations.

dren and will further serve to stigmatize the recipient of the court endorsed commitment. In my opinion, it retards society's progress of recent years in encouraging parents to seek treatment and care of a child in need of hospitalization for a mental or emotional disorder. It will likewise retard society's progress toward removing the stigma still associated by some with psychiatric care. The majority opinion discusses "the stigma associated with civil commitment", yet sets up a system which makes civil commitment necessary. For years now, responsible leaders have been counseling the public that treatment for mental and emotional disorders should be as readily available and as readily acceptable as hospitalization for a tonsillectomy or appendectomy. It certainly will not encourage parents to seek hospitalization for a mentally or emotionally disturbed child when the parent learns that counsel will be appointed for the child and that there will be an adversary hearing at which parents will be subjected to cross-examination as to their motives for seeking hospitalization.

COURT'S PROPOSED ORDER—SEPTEMBER 16, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, Individually and as Hospital Director of Haverford State Hospital, et al.

ORDER

Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

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HUYETT, J. September , 1975

On July 24, 1975, we filed our opinion and order in this action granting judgment in favor of plaintiffs and against defendants. Pursuant to Fed. R. Civ. P. 58 and 65(d), we now enter the following Order to provide and implement the declaratory and injunctive relief to which we held plaintiffs entitled in our opinion.

CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b)(2). The class represented by the named plaintiffs includes all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966. 50 P.S. §§4402 and 4403 (§§402 and 403).

DECLARATORY JUDGMENT

2. Section 402(a)(2), section 402(c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

Notice

3. These sections of the Act are declared invalid in that they fail to require that children eighteen years of age or younger receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, it is declared that this notice must be sent not only to the child but also the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

Counsel

4. These sections of the Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel for children eighteen years of age or younger and, if the child is indigent, appointment of free counsel.

Presence of Child

5. These sections of the Act are declared invalid in that they fail to afford to children eighteen years of age or younger subject to commitment hearings the rights to presence with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

Standard of Proof

6. These sections of the Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a child eighteen years of age or younger find by clear and convincing proof that the child is in need of institutionalization.

Probable Cause Hearing

7. These sections of the Act are declared invalid in that they permit detention of children eighteen years of age or younger for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 3 through 5 above.

Full Commitment Hearing

8. These sections of the Act are declared invalid in that in the event the initial hearing determines the existence of probable cause, they fail to afford to children eighteen years of age or younger a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 3 through 6 above.

Regulations

9. The regulations promulgated by defendant Wohlgemuth to supplement these sections of the Act, published at 3 Pa. Bull. 1840, are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all children eighteen years of age or younger the rights delineated in paragraphs 3 through 8 above.

Admissions and Commitments of Plaintiffs

10. It is declared that all children eighteen years of age or younger admitted or committed to mental health facilities in Pennsylvania under these sections of the Act are unconstitutionally held and detained.

Use of State Courts

11. Until the legislature establishes in accord with our opinion and orders an alternate neutral tribunal to conduct the probable cause and full commitment hearings, it is declared that the present facilities of the Commonwealth court system be used for these hearings.

Application for Treatment of Juveniles

12. It is declared that a parent, guardian, or person standing in loco parentis may initiate the temporary detention of a child eighteen years of age or younger in a mental health facility if the procedures and requirements of our opinion and order are fully complied with.

Requirements for Commitment

13. It is declared that all children eighteen years of age or younger who have been, are, or may be subject to admission or commission to a mental health facility in Pennsylvania are entitled to:

Notice

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

Counsel

B. Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

Presence of Child and Other Hearing Rights

C. Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

Standard of Proof

D. A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

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Probable Cause Hearing

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

Full Commitment Hearing

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

Waiver

14. Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 13 may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

INJUNCTIVE RELIEF

---

15. It is ordered that the operation of section 402(a)(2), section 402(c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) is enjoined in that these sections of the Act are unconstitutional on their face and as applied under the due process

clause of the Fourteenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any child eighteen years of age or younger under the Act to any mental health facility unless the child is or has been provided:

(1) Prior written notice of the date, time and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature established some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

(2) Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

(3) Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 15(A) may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

Regulations

B. To promulgate and issue regulations and to publish them, within thirty (30) days as immediately effective, requiring that all mental health facilities in Pennsylvania (*see* 50 P.S. §4102 for the definition of "facility") adhere to the opinion and order in this action.

Notice of Order

C. To give notice forthwith to all state school and mental hospital directors and their delegates and all directors of all other mental health facilities in Pennsylvania of the opinion and order in this action. Further, to give notice forthwith to all judges of the Courts of Common Pleas in Pennsylvania of the opinion and order in this action.

Access for Attorneys

D. To provide to attorneys access to the grounds and facilities of all mental hospitals and institutions, to their individual clients, and to the institutional and hospital records pertaining to their clients' commitments.

Procedures for Children Already Admitted or Committed

E. To initiate procedures, commencing immediately, to assure that all children eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 are either discharged or released or recommitted according to the procedures required by our opinion and order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and twenty (120) days of the date of this order. Notation shall be made upon the medical records of such children that their discharge, release, or recommitment was effected pursuant to the opinion and order in this action.

Reports on Implementation

F. To report to this Court within sixty (60) days and again within one hundred and fifty (150) days on the steps taken and progress made in the implementation of our opinion and order. The one hundred and fifty-day report shall describe, for each mental health facility, the number of children eighteen years of age or younger released, discharged, or recommitted.

C. J.

D. J.

D. J.

DEFENDANTS' EXCEPTIONS TO COURT'S PROPOSED ORDER—OCTOBER 17, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Title omitted in printing]

EXCEPTIONS TO PROPOSED ORDER

The Defendants by their counsel, Barry A. Roth, Assistant Attorney General, hereby take exceptions pursuant to Federal Rule of Civil Procedure 46 to the Proposed Order which was issued in the above-captioned matter on or about the 16th day of September, 1975, and make the following representations:

1. The Opinion in this matter was issued on July 24, 1975. (Exhibit A) (22a).

2. A dissenting opinion in this matter was issued on August 7, 1975. (Exhibit B) (52a).

3. Pursuant to This Honorable Court's instruction, Defendants submitted a proposed form of final order (attached hereto as Exhibit C and made a part hereof) (72a) together with an accompanying letter dated August 21, 1975 (attached hereto as Exhibit D and made a part hereof).

4. Pursuant to This Honorable Court's instruction, Plaintiffs submitted a proposed form of final order (at-

tached hereto as Exhibit E and made a part hereof) (62a) together with an accompanying letter dated August 5, 1975 (attached hereto as Exhibit F and made a part hereof), and in addition, a response letter to Defendants' August 21, 1975 letter (see Exhibit D) (attached hereto as Exhibit G and made a part hereof).

5. This Honorable Court submitted a proposed order to all counsel of record for comment (attached hereto as Exhibit H and made a part hereof) (77a).

6. Defendants hereby propound the following exceptions to This Honorable Court's proposed order (see Exhibit H):

A. Paragraph 3 requires that a child's attorney must receive notice of the probable cause hearing or post-commitment hearing 48 hours prior to that hearing; however, there is no method by which the Commonwealth, and in particular the Pennsylvania Department of Public Welfare can even attempt to assure that an attorney who is not yet appointed or selected will be in receipt of that notice.

B. Paragraph 3 requires that notice be sent to the child and the clerk of courts for forwarding to the child's attorney and that a probable cause hearing be held within 72 hours from the date of the child's detention. However, the proposed order does not establish if the child may be detained in the event the child's attorney is not appointed within the 72-hour period. The Opinion, however, states, "in no event shall detention of the child in the absence of a probable cause hearing exceed seventy-two (72) hours from the date of the initial detention." (Exhibit A, p. 16).

C. Paragraph 3 requires notice to be sent by, we assume, the Department of Public Welfare to the Court who, in turn, sends it to counsel for the child, and this must be accomplished within 24 hours of the child's admission. The Department cannot assure that an unknown attorney will receive notice of the child's admission 48 hours prior to the probable cause hearing and 24 hours after the juvenile was admitted; however, address has not been made, if the conditions above were met, if an attorney can adequately prepare his case within 24 hours before the hearing.

D. Paragraph 3 requires notice of the child's admission/commitment be sent to the clerk of the court with jurisdiction; however, is jurisdiction to be determined by the location of the institution or by the county from which the child came?

E. Paragraph 3 fails to provide notice to the parent, guardian, or juvenile's applicant.

F. No provision has been made for a continuance, either by the juvenile, parent, hospital, or master.

G. Paragraphs 5 through 8 and 13 require legal representation for the juvenile. The Commonwealth does not object to representation of children by attorneys; however, in light of *Edleman v. Jordan*, this proposed order compels the State to expend funds from its treasury to pay for counsel for indigent juveniles without legislative authority and appropriations. Our order suggests that the public defender or an alternative organization like community legal services which have statutory or clear grant respon-

sibility to accept as clients all who fall within economic guidelines, be referred the cases of indigent juveniles. No standards of indigency have been set forth and a serious question arises if the parent must pay for counsel to his child. Otherwise, until the Legislature provides an alternative source of counsel for indigent juveniles involved in these types of proceedings, it would be unlawful for This Court to order the Commonwealth to pay for said attorneys.

H. Paragraph 11 designates the Commonwealth Court system as the judicial system for the probable cause and full commitment hearings. This Court is thus creating a cause of action in a separate judicial system without a present legislative or common law foundation. As of October 2, 1975, in an amended petition of writ of habeas corpus, petitioner seeks to have declared Section 408 of the Mental Health and Mental Retardation Act of 1966 unconstitutional because there is a violation of equal protection according to the procedural requirements set forth in *Bartley. In re Bingaman,* Common Pleas Court of Snyder County, No. 496, 1975. It is unclear and a matter of substantial controversy whether a Federal District Court has the authority under the Constitution of the United States or any act of Congress to exercise such direction and control over the Commonwealth's judicial branch of government and its judicial officers.

I. In paragraph 11 This Honorable Court declares that the present facilities of the Commonwealth Court system be used for these hearings and directs that the Legislature order an alternate neutral tribunal

to conduct probable cause and full commitment hearings (Exhibit H, p. 4). However, This Honorable Court fails to realize that the Legislature may provide for an equally constitutional method other than by using the Commonwealth Court system, such as the use of a masters (which is prevalent in the 406 commitment process).

J. Paragraphs 13 and 15 provide the child with an opportunity to offer testimony of witnesses; however, who bears the expense for professional testimony such as psychiatric or psychological testimony? This requirement compels the State to expend funds from its treasury to pay for services which are in direct violation of *Edleman v. Jordan.*

K. Paragraph 15(E) requires the discharge, release, or recommitment of institutionalized juveniles to be accomplished within 120 days from the date of this order. This Honorable Court is without jurisdiction and without authority to order the release or conditional release of juveniles already in custody at State institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. Further, pursuant to 28 U.S.C. §2254(b), exhaustion of state remedies is a prerequisite to federal jurisdiction in habeas corpus proceedings. The presentation of a civil rights claim requires no such exhaustion; however, it is not permissible to pursue a habeas corpus remedy through a civil rights action and thus avoid the necessity of referring to the state judicial system for habeas corpus. *Preiser v. Rodriguez,* 411 U.S. 475 (1973).

L. Paragraph 15(E) requires the discharge, release, or recommitment of all juveniles within 120 days from the date of this order. As previously stated, This Court is without jurisdiction and authority to order the release or conditional release of juveniles already in custody at state institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). The Department cannot programmatically effectuate the Court's requirement to recommit all institutionalized juveniles within 120 days and will have no choice but to discharge this group which approximates 7,000 juveniles to their parents and guardians. No aftercare is provided. The effect of this requirement will cause great harm to this class, the majority of which are severely retarded. Furthermore, discharge in several instances may not occur because parents may refuse to have their child returned to them and appropriate proceedings before the local court will be needed to effectuate appointment of a guardian ad litem for the child.

M. Paragraph 15(E) requires the discharge, release, or recommitment of all juveniles within 120 days from the date of this order. As previously stated, This Court is without jurisdiction and authority to order the release or conditional release of juveniles already in custody at state institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). It is recommended that notation of each child's condition be made upon the child's medical

record and forwarded to a guardian ad litem to be appointed by This Honorable Court for the express purpose of seeking a writ of habeas corpus action for each child whom the guardian ad litem feels is inappropriately institutionalized. More than 7,000 juveniles are currently located in State mental hospitals, State schools and hospitals, private licensed facilities, etc., and the majority of these children are severely retarded thereby making them incapable of exercising any judgment regarding their commitment.

N. Paragraph 15(F) requires time limits. It is impossible to implement some or all of the requirements of This Court's proposed order within the time indicated for reporting on implementation. Legislative authority is requisite to most, if not all of the proposed procedures required by paragraph 15 of the proposed order. Since the Legislature convened only for a brief session in September and October, and does not reconvene until after the general election in November, at least 180 days from the issuance of the final order is necessary for the Legislature to authorize implementation of appropriate procedures. The Department of Public Welfare has discussed and sent to Senator Louis Coppersmith copies of the Court's Opinion and our exceptions thereto for introducing legislation.

O. An affidavit by Stanley Meyers, Deputy Secretary for Mental Retardation, setting forth the difficulties of implementing This Court's proposed order is attached as Exhibit I.

P. An affidavit by Dr. James Harris, Deputy Secretary for Mental Health and Medical Services

and Commissioner of Mental Health, sets forth the difficulties of implementing This Court's proposed order and is attached as Exhibit J.

Q. The proposed order erroneously makes no provision allowing for the continuation of the "respite care" program or the intensive training program within the Mental Health/Mental Retardation program of the Commonwealth.

R. The Pennsylvania Court Administrator has informed us that he will be writing to the Court and excepting to the proposed order. He is a necessary party to these proceedings and the Commonwealth subscribes to his objections insofar as they effect the Commonwealth.

S. Paragraph 15(F) requires us to submit reports within 60 days and within 150 days a report of our progress and implementation of the proposed order. It is impossible for the reasons mentioned heretofore to accomplish the structure set forth by This Honorable Court within the time limits. Accordingly, we submit that progress reports be afforded to This Honorable Court every three months until accomplishment of the order occurs, and at that time a full report setting forth the number of children 18 years of age or younger who are committed pursuant to Sections 402 and 403 of the Act.

7. General Exceptions

A. This Court is without jurisdiction and without authority to order the release or conditional release of juveniles already in custody at State institutions within the context of this civil rights action.

The *exclusive method* by which such relief may be obtained is habeas corpus. Further, pursuant to 28 U.S.C. 2254(b), exhaustion of state remedies is a prerequisite to federal jurisdiction in habeas corpus proceedings. The presentation of a civil rights claim requires no such exhaustion; however, it is not permissible to pursue a habeas corpus remedy through a civil rights action and thus avoid the necessity of referring to the state judicial system for habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). Additionally, Plaintiffs never sought release of juveniles in State mental health facilities.

B. This Court's proposed order compels the State to expend funds from its treasury to pay for counsel for indigent juveniles without legislative authority and appropriations. This action is in direct violation of *Edleman v. Jordan*, 415 U.S. 651 (1974).

C. It is unclear and a matter of substantial controversy whether a Federal District Court has the authority under the Constitution of the United States or any act of Congress to exercise such discretion and control over the Commonwealth's judicial branch of government and its judicial officers. Thus, This Court, in essence, has created a cause of action in a separate judicial system without a present legislative or common law foundation. To wit, an amended petition of writ of habeas corpus has been filed in the Common Pleas Court of Snyder County, No. 496, 1975 term, in which petitioner seeks to have declared unconstitutional Section 408 of the Mental Health and Mental Retardation Act of 1966 because there is a violation of equal protection according to the pro-

cedural requirements set forth in *Bartley. In re Bingaman.*

D. While there may have been evils within existing State laws, it is case legend that the protection afforded is a matter for legislative judgment. Consequently, it would be improper to have a permanent order substitute for legislative judgment *Gunn v. University Committee To End the War in Vietnam,* 399 U.S. 383 (1970); *Robinson v. Cahill,* 62 N.J. 473, 520, 521, 303 A.2d 273, 298 (1973); *Federal Power Commission v. National Gas Pipeline Company,* 315 U.S. 575, 599, 601 (1942); *Marbury v. Madison,* 2 L.Ed. 60.

Respectfully submitted,

(s) Barry A. Roth
Barry A. Roth
Assistant Attorney General

Paul J. Carey, Jr.
General Counsel

Robert P. Kane
Attorney General

323 Health and Welfare Building
Harrisburg, Pennsylvania 17120
(717) 787-6398
October 17, 1975

FINAL ORDER—NOVEMBER 17, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, Individually and as Hospital Director of Haverford State Hospital, et al.

ORDER

Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

HUYETT, J. November 17, 1975:

On July 24, 1975, we filed our opinion and order in this action granting judgment in favor of plaintiffs and against defendants. Pursuant to Fed. R. Civ. P. 58 and 65(d), we now enter the following Order to provide and implement the declaratory and injunctive relief to which we held plaintiffs entitled in our opinion.

CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b)(2). The class represented by the named plaintiffs includes all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health or mental retardation facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966. 50 P.S. §§4402 and 4403 (§§402 and 403).

DECLARATORY JUDGMENT

2. Section 402(a)(2), section 402(c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

Notice

3. These sections of the Act are declared invalid in that they fail to require that children eighteen years of age or younger receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, it is declared that this notice must be sent not only to the child but also the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

Counsel

4. These sections of the Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel for children eighteen years of age or younger and, if the child is indigent, appointment of free counsel.

Presence of Child

5. These sections of the Act are declared invalid in that they fail to afford to children eighteen years of age or younger subject to commitment hearings the rights to presence with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

Standard of Proof

6. These sections of the Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a child eighteen years of age or younger find by clear and convincing proof that the child is in need of institutionalization.

Probable Cause Hearing

7. These sections of the Act are declared invalid in that they permit detention of children eighteen years of age or younger for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 3 through 5 above.

Full Commitment Hearing

8. These sections of the Act are declared invalid in that in the event the initial hearing determines the exis-

tence of probable cause, they fail to afford to children eighteen years of age or younger a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 3 through 6 above.

Regulations

9. The regulations promulgated by defendant Wohlgemuth to supplement these sections of the Act, published at 3 Pa. Bull. 1840, are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all children eighteen years of age or younger the rights delineated in paragraphs 3 through 8 above.

Admissions and Commitments of Plaintiffs

10. It is declared that all children eighteen years of age or younger admitted or committed to mental health or mental retardation facilities in Pennsylvania under these sections of the Act are unconstitutionally held and detained.

Use of State Courts

11. Until the legislature establishes in accord with our opinion and order an alternate neutral tribunal to conduct the probable cause and full commitment hearings, it is declared that the present facilities of the Commonwealth court system be used for these hearings.

Application for Treatment of Juveniles

12. It is declared that a parent, guardian, or person standing in loco parentis may initiate the temporary detention of a child eighteen years of age or younger in a mental health or mental retardation facility if the procedures and requirements of our opinion and order are fully complied with.

Requirements for Commitment

13. It is declared that all children eighteen years of age or younger who have been, are, or may be subject to admission or commission to a mental health or mental retardation facility in Pennsylvania are entitled to:

Notice

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

Counsel

B. Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

Presence of Child and Other Hearing Rights

C. Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

Standard of Proof

D. A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

Probable Cause Hearing

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

Full Commitment Hearing

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

Waiver

14. Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 13 may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

INJUNCTIVE RELIEF

---

15. It is ordered that the operation of section 402 (a) (2), section 402 (c), except for the language "any

person voluntarily admitted shall be free to withdraw at any time," and section 403 (a) (2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) is enjoined in that these sections of the Act are unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any child eighteen years of age or younger under the Act to any mental health or mental retardation facility unless the child is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

(2) Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

(3) Presence of the child at all commitment hearings, an opportunity to be heard, confrontation

and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 15(A) may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

Regulations

B. To promulgate and issue regulations and to publish them, within thirty (30) days as immediately effective, requiring that all mental health and mental retardation facilities in Pennsylvania (*see* 50 P.S. §4102 for the definition of "facility") adhere to the opinion and order in this action.

Notice of Order

C. To give notice forthwith to all state school and mental hospital directors and their delegates and all directors of all other mental health and mental retardation facilities in Pennsylvania of the opinion and order in this action. Further, to give notice forthwith to all judges of the Courts of Common Pleas in Pennsylvania of the opinion and order in this action.

Access for Attorneys

D. To provide to attorneys access to the grounds and facilities of all mental hospitals and institutions, to their individual clients, and to the institutional and hospital records pertaining to their clients' commitments.

Procedures for Children Already Admitted or Committed

E. To initiate procedures, commencing immediately, to assure that all children eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 are either discharged or released or recommitted according to the procedures required by our opinion and order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and twenty (120) days of the date of this order, unless an extention is granted by this Court for good cause shown. Notation shall be made upon the medical records of such children that their discharge, release, or recommitment was effected pursuant to the opinion and order in this action. In addition, any person admitted or committed pursuant to §§402 or 403 at a time when he or she was eighteen years of age or younger but who has reached his or her nineteenth birthday shall be brought before a Commonwealth court or alternate neutral tribunal and informed of his or her options under §§402 and 403 for

voluntary withdrawal. Should such person choose to withdraw voluntarily, he or she shall be released immediately unless proper procedures are initiated pursuant to the appropriate Pennsylvania statutes governing the involuntary commitment of adults.

Reports on Implementation

F. To report to this Court within sixty (60) days and again within one hundred and fifty (150) days on the steps taken and progress made in the implementation of our opinion and order. The one hundred and fifty-day report shall describe, for each mental health or mental retardation facility, the number of children eighteen years of age or younger released, discharged or recommitted and the number of persons who have reached their nineteenth birthday but who were eighteen years of age or younger at the time they were admitted or committed pursuant to §402 or §403 who have been released, voluntarily admitted or committed, or involuntarily committed.

(s) John J. Gibbons
C. J.

(s) Daniel A. Huyett 3rd
D. J.

(s) R. J. Broderick
D. J.

NOTICE OF APPEAL

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley; Steve Gentile; Lesile Levine; Vicki Mathews; Mark Weand; minors, through their next friend, individually and on behalf of all others similarly situated,
Plaintiffs

v.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
Defendants

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that Jack B. Kremens, et al., the Defendants above-named, hereby appeal to the Supreme Court of the United States from the final order granting a permanent injunction in favor of Plaintiffs and

against Defendants, entered in this action on November 17, 1975.

This appeal is taken pursuant to 28 U.S.C. §1253.

(s) Barry A. Roth
Barry A. Roth
Assistant Attorney General
Counsel for Defendants

[Caption Omitted]

AFFIDAVIT OF SERVICE

Barry A. Roth certifies that he, by certified mail, return receipt requested, served:

David Ferleger, Esq.
1427 Walnut Street
Philadelphia, Pa. 19102

John Gabroy, Esq.
1710 Spruce Street
Philadelphia, Pa. 19103

Thomas B. Harvey, Jr.
American Civil Liberties Foundation
260 South 15th Street
Philadelphia, Pa. 19102

Jay Stanley Pottinger
Assistant U. S. Attorney General
Department of Justice
Washington, D.C. 20530

Robert C. Burgdorf
National Association for Retarded Citizens
1235 North Eddy Street
South Bend, Indiana 46617

Peter Sandman
Youth Law Center of California
795 Turk Street
San Francisco, California 94102

by sending them a copy of the Notice of Appeal at the above address.

(s) Barry A. Roth
Barry A. Roth
Assistant Attorney General

Dated:

Sworn to and subscribed before me on this 24th day of November, 1975.

[Illegible]
Notary Public

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1975
No.

[Title omitted in printing.]

To Mr. Justice Brennan, Circuit Justice:

APPLICATION FOR A STAY[1]

Appellants, by this application, *inter alia* seek to protect the integrity of the Commonwealth of Pennsylvania's legislative, judicial and executive branches of government as well as the Commonwealth's general fund in keeping with this court's holding in *Edelman v. Jordan*, 415 U.S. 651 (1974). Moreover, the appellants seek to preserve the delicate balance between competing jurisdictions in the traditional area of habeas corpus relief as set forth by this Court in *Preiser v. Rodriguez*, 411 U.S. 475 (1973).

The order of the lower court enjoining the continued use of Pennsylvania's statutes which prescribe the method by which juveniles may be voluntarily committed to mental health facilities in Pennsylvania[2] (See pp. 1, 2 of Exhibit

[1] The Defendants' Motion for a Stay was denied by the lower Court on December 2, 1975 (Motion and Order attached hereto as Exhibit A).

[2] Act of October 20, 1966, special sess. No. 3, P.L. 96, art. IV, §§402, 403, 50 P.S. §§4402, 4403 (1966).

(D)) must be stayed pending review by this Court in order to prevent an irreversible injury to the aforementioned interests of the Commonwealth. In support of this application, the appellants assert:

PROCEEDINGS BELOW

1. This class action was brought under the Civil Rights Act, 42 U.S.C. §1983 and sought both declaratory and injunctive relief against the continued operation of sections 402 and 403 of Pennsylvania's Mental Health and Mental Retardation Act. A three judge court was convened and a majority thereof issued the attached opinion on July 24, 1975 (See Exhibits B and C).[3] And finally, over defendants' strong objections, on November 17, 1975, the final order was issued in this case (Exhibit D).

2. The Defendants took formal exceptions to the lower Courts' order (Exhibit B and F).

REASONS FOR GRANTING THE STAY

3. This action constituted a challenge to the legality of the plaintiffs' confinement in the various mental health and mental retardation facilities throughout the Commonwealth.

4. Pennsylvania law specifically provides that habeas corpus is the remedy to be used in challenging the legality of one's confinement. Section 426 of the Mental Health and Mental Retardation Act of 1966 provides in relevant part:

"Every person committed or detained in a facility by reason of the provisions of this act or anyone

[3] District Judge Broderick dissented (Exhibit B).

acting on his behalf, may at any time, petition for a writ of habeas corpus and, except as hereinafter provided, said petition shall be filed in accordance with the provisions of the Act of May 25, 1951 (P.L. 415) [note omitted].

(b) Said petition may be based upon the following grounds:

(1) the insufficiency or illegality of the proceeding leading to such person's commitment . . ."

5. Moreover, this Court has held that it is improper for a federal court to entertain a civil rights action which challenges the legality of one's confinement. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). This Court specifically held that in cases such as those described below, the exclusive remedy is habeas corpus and that a civil rights action was not a permissible alternative.

"Thus, whether the petitioner's challenge to his custody is that the statute under which he stands convicted is unconstitutional, as in Ex parte Siebold, supra; that he had been imprisoned prior to trial on account of a defective indictment against him, as in Ex parte Royall, 117 U.S. 241, 6 S.Ct. 734, 29 L.Ed. 868 (1886); that he is unlawfully confined in the wrong institution, as in In re Bonner, 151 U.S. 242, 14 S.Ct. 323, 38 L.Ed. 149 (1894), and Humphrey v. Cady, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394 (1972); *that he was denied his constitutional rights at trial*, as in Johnson v. Zerbst, supra; that his guilty plea was invalid, as in Von Moltke v. Gillies, 332 U.S. 708, 68 S.Ct. 316, 92 L.Ed. 309 (1948); that he is being unlawfully detained by the Executive or the military, as in Parisi v. Davidson, 405 U.S. 34, 92 S.Ct. 815, 31 L.Ed.2d 17 (1972); or that his parole was unlawfully revoked, causing him to be reincarcerated in prison, as in Morrissey v. Brewer, 408 U.S. 471, 92 S.Ct. 2593, 33 L.Ed.2d 484 (1972)—*in each case his grievance is that he is being unlawfully subjected to physical restraint, and in each case habeas corpus has been accepted as the specific instrument to obtain release from such confinement.* [note omitted]" (Emphasis added.) 411 U.S. at 486.

6. The lower court in this case not only entertained plaintiffs' challenge to the fact of their confinement within the context of a civil rights action, and thus did not require exhaustion of state remedies, but also ordered that all of the thousands of plaintiffs either be released from confinement, or recommitted pursuant to the procedures established by the court within 120 days. (See Exhibit D, pp. 8-9, para. 15E).

7. The rule of *Preiser* applies fully to this case and all of the considerations underlying that decision, including considerations of comity are applicable to this case.

8. Notwithstanding the fact that a new cause of action in the Commonwealth of Pennsylvania was created by the lower court in this case, the Court Administrator's Office which is the official administrative arm of the Commonwealth's judiciary was not formally brought into this action as a party.

9. The Court Administrator was permitted to comment on the order before it was adopted (Exhibit G).

10. The Court Administrator has informed the lower court of its disapproval of the Order in this case to

the extent that a massive additional case load has been immediately placed upon the dockets of the courts of general jurisdiction in the Commonwealth of Pennsylvania.

11. The lower court's action in this case constitutes improper judicial legislation. Moreover, the order in this case is not narrowly drawn to effectuate its decision, but rather presumes to establish an entire system of juvenile admissions to mental health and mental retardation facilities. As such, the order in this case will cause administrative confusion, unduly interfere with the legislative process, and runs contra to the rule of this court in *Graves v. Barnes*, 405 U.S. 1201 (1972). (See Meyers & Harris affidavits, Exhibits I & J).

12. In short, the order of the lower court has required "the impossible" of the Commonwealth's judiciary and executive, and has preempted the legislature from performing its role in this area of needed legislative action (See letter from Court Administrator to Presiding Judge, Exhibit H).

13. In violation of the Eleventh Amendment to the Constitution of the United States and this Court's holding in *Edelman v. Jordan, supra,* the lower court has ordered that the full panoply of due process rights including the rights to a hearing and counsel be provided retroactively to *all* juveniles presently incarcerated in a mental health or mental retardation facility in the Commonwealth of Pennsylvania.

14. As in *Edelman*, the district court here has issued both prospective and retroactive relief, and as in *Edelman* the retroactive relief was structured to conform with the prospective injunctive relief. And again, as in *Edelman*, "the funds to satisfy the award [retroactive relief] in this

case must inevitably come from the general revenues of the [s]tate . . . ," *id.* at 459. Therefore, the rule of *Edelman* requires reversal of at least this aspect of the lower court's holding.

15. The lower court in this case has ordered the Commonwealth to expend funds from its general fund to provide commitment procedures retroactively even though the Commonwealth "was under no court-imposed obligation to conform to a different standard" *Edelman, supra* at 668.

16. The issues in this case are extremely significant *Times-Picayune Publishing Corp. v. Schulingkamp,* 419 U.S. 1301 (1974). In fact there are currently pending many lawsuits in federal courts involving juveniles' due process rights in the mental health area which will inevitably involve issues similar to those raised by this application and appeal, e.g., *Kidd v. Schmidt,* No. 74-C-605 (E.D. Wisc.); *Poe v. Weinberger,* No. 74-1800 (D.D.C.); *Brown v. Allerton,* No. 75-0450 (E.D. Va.); *Goldy v. Beal,* No. 75-791 (M.D. Pa.) thus it is of critical importance in this area that this Court resolve the fundamental jurisdictional and constitutional questions presently being raised.

17. There is a substantial likelihood of reversal of, at the very least, some of the relief ordered by the lower court on the basis of issues raised by this application and appeal, *Graves v. Barnes,* 405 U.S. 1201 (1972).

18. It is clear that should the requested stay be denied the Commonwealth could never be restored to the *status quo ante* see *Edelman v. Jordan,* 414 U.S. 1301, 1302-3 (1973). All of the funds expended in complying

with the retroactive award of relief would of course be totally irretrievable by the Commonwealth in this case, see also *King v. Smith*, 88 S.Ct. 842 (1968).

19. Similarly, the administrative and judicial disruption and confusion that will result from attempts to implement this decree will cause irreparable harm to the Commonwealth should the lower court's order not be stayed pending this appeal. (See Meyers and Harris affidavits as well as Court Administrator's Letter, Exhibits I, J and H).

20. The plaintiffs will suffer no irreparable harm for there is always available to them the full and complete remedy of habeas corpus pursuant to 50 P.S. §4426.

21. If the stay is not granted in this case judicial review of most, if not all, of appellants' contentions will be precluded because those issues will be moot. This court has in the past found considerations of mootness to be appropriate and sufficient in deciding whether or not to grant a stay of an injunction. In *Republican State Central Committee v. Ripon Society*, in 409 U.S. 1222, 1225 (1972) this Court held that:

> "the fact that a stay here, instead of precluding any judicial review . . . preserves these issues for review in a manner conducive to careful study and consideration is itself a reason to stay the injunction."

See also, *Parisi v. Davidson*, 396 U.S. 1233 (1969); *Public Service Board v. United States*, 87 S.Ct. 3 (1966) and *Bandy v. United States*, 82 S.Ct. 11 (1961).

22. The appellants stand ready to file their jurisdictional statement in such time as this court may direct and thus urge that any delay in the implementation of

the relief ordered by the lower court can be minimized by the granting of an expeditious appeal. *National League of Cities v. Brennan*, 419 U.S. 1321 (1974) (stay granted) 419 U.S. 1100 (1974) (Stay continued; time for jurisdictional statement and response shortened); *Smith v. Richey*, 89 S.Ct. 55 (1968) (stay granted with conditions of expedition).

23. Defendants respectfully request that should this request for a stay be denied that such denial be without prejudice. *National Labor Relations Board v. Getman*, 404 U.S. 1204 (1971).

WHEREFORE, the defendants urgently request that this Court stay the order of the lower court in pending full appellate review of the issues presently before the Court.

Respectfully submitted,

(s) Norman J. Watkins
Norman J. Watkins
Deputy Attorney General

Barry A. Roth
Assistant Attorney General

Robert P. Kane
Attorney General

Of Counsel: Jeffrey Cooper

Dated: December 8, 1975

WESTERN UNION
TELEGRAM

TO: THE CHIEF JUSTICE AND JUSTICES OF THE SUPREME COURT OF THE UNITED STATES 1 FIRST STREET N.E. WASHINGTON D.C. 20543

RE: KREMENS v. BARTLEY, APPEAL FROM U.S. DISTRICT COURT, E.D. PA. #72-2272—REQUEST FOR STAY

ORDER APPEALED FROM CALLS FOR JUDICIAL INTERVENTION IN ESTIMATED SIX TO EIGHT THOUSAND CASES WITHIN FIVE MONTHS. COURT ADMINISTRATOR OF PENNSYLVANIA PREPARING TO INTERVENE IN THE ACTION, IF POSSIBLE, AND HE AND THIS COURT JOIN WITH THE COMMONWEALTH IN THE REQUEST FOR A STAY. FAILURE OF STAY WILL RESULT IN OVERWHELMING AND DISRUPTING THE JUDICIAL SYSTEMS OF PENNSYLVANIA WHICH ARE ALREADY OVERLOADED WITH REGULAR COURT BUSINESS.

BENJAMIN R. JONES
CHIEF JUSTICE OF PENNSYLVANIA

HON. THURGOOD MARSHALL
HON. HARRY A. BLACKMUN
HON. LEWIS F. POWELL, JR.
HON. WILLIAM H. REHNQUIST

SEND TO: (AT ABOVE ADDRESS)
HON. WARREN E. BURGER
HON. WILLIAM J. BRENNAN, JR.
HON. POTTER STEWART
HON. BYRON R. WHITE

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
Washington, D.C. 20543
December 15, 1975

Norman J. Watkins, Esq.
Deputy Attorney General of
Pennsylvania
Department of Justice
Harrisburg, Pennsylvania 17120

RE: Jack B. Kremens, et al. v. Kevin B. Bartley, et al., No. A-527

Dear Mr. Watkins:

The Court today entered the following order in the above-entitled case:

> The application for a stay of the judgment of the United States District Court for the Eastern District of Pennsylvania (Civil Action No. 72-2272), presented to Mr. Justice Rehnquist and by him referred to the Court, is granted.

Very truly yours,

Michael Rodak, Jr., *Clerk*
by Francis J. Lorson
Francis J. Lorson
Deputy Clerk

cc: David Ferleger, Esquire
1427 Walnut Street
Philadelphia, Pennsylvania 19102

Clerk, USDC for ED Pennsylvania
(No. 72-2272)

Supreme Court, U. S.
FILED
AUG 2 1978
MICHAEL RODAK, JR., CLERK

VOLUME III—Pages 867a-1115a
APPENDIX

In the Supreme Court of the United States

October Term, 1978
No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

APPEAL DOCKETED MAY 31, 1978
JURISDICTION NOTED JUNE 19, 1978

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C.A. No. 72-2272

CIVIL DOCKET CONTINUATION SHEET
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RJB, Gibbons

PLAINTIFF: BARTLEY ET AL.
DEFENDANT: KREMENS ET AL.

Date	Nr.	Proceedings
1975		
	123	—Dec. 18, Plffs' response to Court's Order of 12-12-75 and certificate of service, filed.
1976		
	124	—Feb. 4, Certified copy received from the Supreme Court of the U.S. re filing of petition for a writ of certiorari on 1-27-76 as No. 75-1064, etc., filed.
	125	—Mar. 29, Certified copy received from the Supreme Court of the U.S. re notation of probable jurisdiction, etc., filed.
	126	—Jun. 24, Letter from Clerk of the Supreme Court to Clerk of this Court dated 6-23-76 re: transmittal of record, etc., filed.

127—July 1, Answers of the State Schools and Hospitals, State Mental Hospitals and Private Licensed facilities to the May 31, 1973 questionnaire of plffs., etc., filed.

—July 2, Original record transmitted to U.S. Supreme Court, Not including papers No. 20, 110, 113-115.

1977

128—June 16, Certified copy of Judgment received from the Supreme Court that the Judgment of this Court is VACATED: This cause is remanded to this Court for further proceedings in conformity with this Opinion of the Supreme Court, etc., filed.

129—June 21, Plffs' motion to allow Law Clerks, acting on behalf of and under supervision of attorney and the Guardian Ad Litem of the plff. class to examine medical records of class representatives, certificate of service and memorandum of law in support, filed.

(129)—June 21, ORDER that the defts., et al. shall permit David Ferleger, et al. access to the medical records of members of the plff. class in Penna. state mental institutions, etc., filed. DH 6-22-77 entered and copies mailed.

—July 5, Original record returned from the Supreme Court and forwarded to the U.S.C.A. (Record includes papers No. 1 thru 105—not papers No. 20, 100 and 102).

130—July 8, Plffs' motion to clarify this Court's Order of 6-21-77 and certificate of service, filed.

—July 12, First supplemental record transmitted to U.S.C.A. (Record only includes papers No. 106 thru 129, not including paper No. 113.)

131—July 14, Defts' response to plffs' motion to clarify this Court's Order of 6-21-77 and certificate of service, filed.

(130)—July 25, ORDER that the Order of this Court dated 6-21-77 regarding access is amended, etc., filed. DH 7-26-77 entered and copies mailed.

132—Nov. 2, Plffs' motion to amend and supplement complaint, filed. (Amended and supplemental complaint attached).

133—Nov. 2, Plffs' interrogatories to the defts, filed.

134—Nov. 2, Plffs' certificate of service re: motion to amend, etc., filed.

135—Nov. 9, ORDER dated 11-8-77 that plffs' motion to amend and supplement the complaint is granted: further ordered that the deft shall answer the amended and supplemental complaint within 20 days, filed. DH 11-10-77 entered and copies mailed.

136—Nov. 9, Amended and Supplement Complaint filed.

137—Nov. 11, Entry of appearance of Norman J. Watkins as counsel for defts., Sec'ty of Public Welfare, et al., filed.

138—Nov. 11, Plffs' motion for class action and certificate of service, filed.

139—Nov. 30, Defts' answer and certificate of service, filed.

140—Dec. 5, Brief of Amici Curiae, Pennsylvania Association for Retarded Citizens, Inc. and National Center for Law and the Handicapped, Inc. and certificate of service, filed.

141—Dec. 15, Defts' answer to plffs' interrogatories and certificate of service, filed.

142—Dec 27, Defts' supplemental answers to plffs' interrogatories and certificate of service, filed.

1978

143—Jan. 12, Defts' response to plffs' motion for class action and certificate of service, filed.

144—Feb. 13, Plffs' brief on Class Action and certificate of service, filed.

145—Feb. 13, Plffs' brief on Collateral Estoppel Issue and certificate of service, filed.

146—Feb. 15, ORDER dated 2-13-78 that counsel shall advise the Court by 3-1-78 whether they wish to submit additional evidence, etc., hearing and final argument on the merits shall be held before the Three Judge Court on 3-31-78 entered and copies mailed. DH 2-16-78 entered and copies mailed.

147—Feb. 21, Entry of appearance of Robert B. Hoffman as counsel for defts, filed.

148—Feb. 27, Defts' memorandum in opposition to the United States' request to participate as "litigating amicus" and certain evidentiary matters, and certificate of service, filed.

149—Mar. 1, Plffs' memorandum on evidentiary questions relating to admission and medical records, filed.

150—Mar. 10, ORDER that the findings of fact and conclusions of law contained in C.A. 74-1345 are inadmissible on grounds of relevance, etc., that Judge Gibbons and Judge Broderick have agreed with the

contents of this Order, filed. DH 3/13/78 entered & copies mailed.

151—Mar. 15, Plfts' brief with certificate of service, filed.

152—Mar. 20, Defendants' pretrial memorandum, filed.

153—Mar. 20, Copy of defts' pretrial memorandum containing the typographical corrections, filed.

154—Mar. 20, Defts' motion to file defts' pretrial memorandum one day out of time, and certificate of service, filed.

155—Mar. 28, Memorandum, Huyett J., re plffs' motion for certification of a deft., class, etc., filed. DH 3/29/78 entered & copies mailed.

156—Mar. 28, Order, Huyett J., plffs' motion for certification of a deft., class is granted, etc., filed. 3/29/78 entered & copies mailed. DH

(154)—Mar. 29, Order, Huyett J., that defts are permitted to file their pre-trial memorandum one day out of time, filed. DH 3/30/78 entered & copies mailed.

157—Mar. 31, Final hearing, Huyett, J., re: argument to supplement briefs, court gave counsel till 4/13/78 for any additional supplemental briefs, and took issue under advisement, filed.

158—Mar. 31, Plfts' supplemental brief and certificate of service, filed.

159—Mar. 31, Plfts' offer of proof and request for evidentiary ruling, and certificate of service, filed.

160—Apr. 12, Brief of Amicus curiae, United States and certificate of service, filed.

161—Apr. 13, Deposition of Linda L. Glenn, filed.

162—Apr. 13, Brief of The Devereux Foundation, Amicus Curiae with certificate of service, filed.

163—Apr. 13, Brief of The Melmark Home Inc., The Woods School and The Allegheny Valley School for Exceptional Children as Amici Curiae.

164—Apr. 14, Certificate of Service of Jane B. Porcelan, filed.

165—Apr. 14, Plfts' memorandum on need for judicial hearing, filed.

166—Apr. 14, Plfts' memorandum in opposition to admission of "Part A" of medical records exhibits, filed.

167—Apr. 17, Defendants' supplemental memorandum with certificate of service, filed.

168—May 25, OPINION, Gibbons Circuit J., Huyett, J. & ORDER that judgment is entered in favor of plfts. and against defts. Section 402(a)(2), 402(c), 403(a)(2) of Penna. Mental Health & Mental Retardation Act of 1966 are unconstitutional on their face under due process clause of 14th Amendment, etc., filed. Hon. Raymond J. Broderick dissents & will file a dissenting opinion. (49 pgs. $12.25). 5/25/78 entered & copies mailed.

169—May 30, Notice of appeal of defendants to the Supreme Court of the United States, rec'd. 5/30/78 at 10:05 a.m., filed. 5/31/78 entered & copies to: David Ferleger, Esq., Thomas B. Harvey, Jr., Barry A. Roth, Asst. Atty. General, U.S. Atty. in Phila., Louis M. Thrasher, Asst. Atty. General; Herbert B. Newberg & Associates; Robert B. Hoffman, Esq., Asst. Atty. General.

170—June 2, Letter from David Ferleger, Esq. dated 5/30/78 to Norman Watkins, Esq., re: Order filed 5/25/78, filed.

171—June 14, Dissenting Opinion, Broderick, J., filed. ($3.50, 14 pgs.)

172—June 19, Defts' motion for stay memorandum, affidavit of Gerald F. Radke, and certificate of service, filed.

173—Jun. 26, Plfts' notice of deposition of Gerald F. Radke, filed.

174—Jun. 26, Plfts' opposition to request for a stay and plfts' suggestion of need for hearing, with certificate of service, filed.

175—Jun. 26, Certified copy of Order, Supreme Court of U.S. that probable jurisdiction is noted, filed.

176—Jun. 27, ORDER, that a hearing shall be held on defts' motion for a stay of the Court's Order of 5/25/78, on 7/5/78 at 10 AM, Courtroom 434, Reading Station, American Bank Bldg., 6th & Washington Sts., Reading Pa., etc., filed. DH 6/27/78 entered & copies mailed.

177—July 3, Appearance of Kohn, Savett, Marion & Graf, P.C., by Bayard M. Graf, Esquire, for Harold S. Barbour, Ed. D., Director of The Woods Schools, a mental health & retardation facility in Pa. subject to regulation by the deft., Secretary of Public Welfare, filed.

178—July 3, Appearance of Kohn, Savett, Marion & Graf, P.C., by Bayard M. Graf, Esq., for Paul A. Krentel, Director of The Melmark Home Inc., a mental retardation facility in subject to regulation by the deft., Secretary of Public Welfare, filed.

179—July 5, Hearing on motion for stay order of Court pending disposition of appeal to supreme court, witnesses sworn, court took issue under advisement, filed.

180—July 5, Memorandum of Amicus Curiae, United States, in opposition to defts' motion for a stay, filed.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

C.A. No. 72-2272
(formerly captioned *Bartley v. Kremens*)

Institutionalized Juveniles in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, Kevin S.; Richard S.; James Paul M.; Edward B.; Raymond C.; William B.; Francis B.; Maria L.; Thomas W.; Nancy Louise D.; Gina S.; and George S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Secretary of Public Welfare, Commonwealth of Pennsylvania, Frank Beal; John Fong, Director of Haverford State Hospital; Nicholas D'Aluisio, Director of Polk State School and Hospital; C. Duane Youngberg, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Defendants

AMENDED AND SUPPLEMENTAL COMPLAINT

I. PRELIMINARY STATEMENT

1. Children are persons under the Constitution and laws of the United States and are entitled to their protection.

2. Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief for violations of their civil rights resulting from the operation of Pennsylvania statutes which permit their indeterminate confinement in institutions for the mentally ill and mentally retarded under color of state law with no right to notice, hearing, counsel and other procedural safeguards. The statutes are challenged on the ground that they conflict with the plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

3. The defendants are those state officials who accept and receive into involuntary custody the plaintiffs, minors, upon the request of parents or guardians such as welfare departments and child care agencies.

4. This case has been before the Court as *Bartley v. Kremens,* 402 F.Supp. 1039 (E.D. Pa. 1975), vacated and remanded, 97 S.Ct. 1709 (1977). This amended and supplemental complaint substitutes new class representatives and informs the Court of recent state statutory developments.

II. JURISDICTION

5. Jurisdiction is conferred upon this Court by 28 U.S.C. 1331 which provides for original federal question jurisdiction. The amount in controversy, exclusive of interest and costs, exceeds $10,000.

6. Jurisdiction is also conferred upon this Court by 28 U.S.C. 1343(3) which provides for original jurisdiction in all suits authorized by 42 U.S.C. 1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States and by federal law. Defendants here act under color of state law.

7. Plaintiffs' action for declaratory and injunctive relief is authorized by 28 U.S.C. 2201, 2202, 2281, 2284, Rules 57 and 65 of the Federal Rules of Civil Procedure, all of which relate to declaratory judgments, injunctions and three-judge courts, and by 42 U.S.C. 1983 and 1988, which relate to civil rights actions.

III. THREE-JUDGE COURT

8. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. 2281 and 2284 since the plaintiffs seeks an injunction to restrain defendants, state officials, from the enforcement, execution and operation of portions of state statutes of state-wide applicability on the ground that said statutes are contrary to the United States Constitution. This action was filed prior to the enactment of Public Law 94-381, which amended the three-judge court statutes.

IV. CLASS ACTION ALLEGATIONS

9. The named plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

10. The members of the class of plaintiffs similarly situated are all persons who are or who may be committed to institutions for the mentally ill and the mentally retarded in Pennsylvania upon application of parents or guardians and without notice, hearing, counsel and other procedural safeguards.

a. Subclass A of plaintiffs includes all those persons under 14 years of age committed under Section 201 of the Mental Health Procedures Act of 1976.

b. Subclass B of plaintiffs consists of all persons 18 years of age or younger committed under Sections 402 and 403 of the Mental Health and Retardation Act of 1966.

11. The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical (and the total membership of the class is indeterminate); there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

12. Defendant John Fong, C. Duane Youngberg and Nicholas D'Aluisio, directors of the facilities confining the named plaintiffs, are sued as representative of the class of directors of all mental health and mental retardation facilities in Pennsylvania, all of which are subject to regulation by the defendant Secretary of Public Welfare. All the allegations in Paragraph 11 are met with

respect to this defendant class and those allegations are incorporated here by reference.

13. The questions of law and fact involved are:

a. Are the representative parties, and their class members, committed to mental institutions pursuant to the challenged statutes and without notice, counsel, hearing and other procedural safeguards?

b. Do the defendants operate, execute and enforce the challenged statutes?

c. Are the challenged statutes contrary to the Due Process Clause of the Fourteenth Amendment to the United States Constitution?

V. NAMED PLAINTIFFS

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14. The named plaintiffs sue by their next friend and guardian ad litem, appointed by this Court pursuant to Rule 17 of the Federal Rules of Civil Procedure.

15. Due to the stigma of mental hospitalization and a desire to minimize any possible intrusions on their privacy, the named plaintiffs are designated in this complaint by their actual given names and the initial of their surnames. The full names of the plaintiffs are being disclosed to the defendants and their counsel and will, should the Court desire, be filed with the Court.

16. The first group of plaintiffs, those confined at Haverford State Hospital under the Mental Health Procedures Act of 1976, are *all the juveniles age 14 and*

under committed under Section 201 as of October 31, 1977 to that institution.

17. The second group of plaintiffs are persons with mental retardation confined under the Mental Health and Mental Retardation Act of 1966, Sections 402 and 403 in two institutions, one near Philadelphia in the eastern part of Pennsylvania and one near Pittsburg in the west.

First Group of Plaintiffs; Those at Haverford State Hospital

18. Plaintiff Kevin S., born May 2, 1965, is a citizen of Pennsylvania. He is 12 years old.

19. Plaintiff Richard S. is now 13 years old and a citizen of Pennsylvania. He was born on September 24, 1964.

20. Plaintiff James Paul M. is 7 years old, having been born on November 10, 1969. He is a citizen of Pennsylvania.

21. There is no paragraph 21.

22. Plaintiff Raymond C. was born on September 9, 1964, is a citizen of Pennsylvania, and is 13 years old.

23. Plaintiff William B. was born June 18, 1968, is 9 years old and is a citizen of Pennsylvania.

24. Plaintiff Eddie B. was born October 26, 1965, is a citizen of Pennsylvania and is 12 years old.

25. Plaintiff Francis B. was born January 9, 1967, is 10 years old, and a citizen of Pennsylvania.

26. Maria L., plaintiff in this action, was born August 26, 1965, is 12 years old and a citizen of Pennsylvania.

27. Thomas W., born February 14, 1966, is 11 years old and a citizen of Pennsylvania.

Second Group of Plaintiffs; Those at Pennhurst and Polk State Schools and Hospitals

28. Plaintiff Nancy Louise D., born December 10, 1960, is a 16 year old citizen of Pennsylvania.

29. Plaintiff Gina S. was born on July 30, 1961 and is a citizen of Pennsylvania. She is 16 years of age.

30. Plaintiff George S., was born February 10, 1963, is 14 years old, and is a citizen of Pennsylvania.

VI. DEFENDANTS

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31. Defendant Secretary of Public Welfare is the Pennsylvania State official who, in that capacity, has the power and duty to enforce the challenged statutes and all regulations necessary and appropriate to the proper accomplishment of those provisions and to operate and assign functions to all state facilities. See Sections 201 (2) and 202 (a) of the Mental Health and Mental Retardation Act of 1966, and Section 105 of the Mental Health Procedures Act of 1976 ("Treatment Facilities"), and 6 Pa. Bull. 2115 at Section 7100.1.2 (definition of "approved facility"). Frank Beal currently occupied that office.

32. Defendant John Fong is the director of Haverford State Hospital and is charged with supervision and administration of the facility. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act

of 1966. It is Fong or his delegate that applications for admission, commitment or release of the plaintiffs must be made. Haverford State Hospital is an approved facility under Section 105 of the Mental Health Procedures Act of 1976.

33. Defendants Nicholas D'Aluisio and C. Duane Youngberg are, respectively, directors of the Polk State School and Hospital and the Pennhurst State School and Hospital, both institutions for persons with retardation. They are charged with supervision and administration of those facilities. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act of 1966. It is to D'Aluisio, Youngberg or their delegates that applications for admission, commitment or release of the plaintiffs must be made. See Sections 402(b), 403(b) and 403(c) of the Mental Health and Mental Retardation Act of 1966.

VII. FACTUAL ALLEGATIONS

Haverford State Hospital

34. Haverford State Hospital is an institution for the mentally ill located in a rural area outside Philadelphia, Pennsylvania.

35. The institution's score of buildings cover a large hilly area in one corner of which is Building 14, a building with two large wards. The west ward houses geriatric patients; the door to it is generally unlocked. The east ward houses juveniles.

26. As of October 31, 1977, there were a total of 12 juveniles in Building 14. Two were committed by

juvenile courts, after hearing; ten were committed under the challenged statutes, having been "volunteered" into the institution by parents or guardians.

27. Entry into the Children's Unit in Building 14 is through a door that is kept locked. When a buzzer is rung, a worker inside comes to unlock the door. The door bears a sign which reads, "Visiting Hours—1:30-4:30 Weekends and Holidays. No evening visits. (signed) Dr. Bernard Kanther."

28. The Unit consists of two hallways which cross at a glass-walled nursing station. One hallway continues from the entrance door to a large dormitory area for male patients. Along that hallway are two bare unfurnished rooms used for "seclusion" or "time-out" purposes. The second hall has a large dayroom at one end and, at the other end, a large dormitory for female patients.

29. In the nursing station is a bank of television monitors which are used to surveil the patients in all areas of the Unit, including the halls and dormitories.

30. Adjacent to the building are playing areas fenced in by chain link fences about 12 feet high.

32. Patients, including the plaintiffs, are punished for misbehavior and for disobedience to staff, and for violations of unit rules in a variety of ways including: restriction to the Unit, "meditation" (an enforced period of standing or sitting in the hallway, with the person forbidden to converse or interact with other patients passing to and fro), or "time out" (lock-up in a bare unfurnished room, including overnight periods, alone).

33. Patients have also been pushed, shoved, slapped and hit by institutional staff with no justification. Pa-

tients have been forcibly medicated with intra-muscular injections as punishment for "acting out" and for the convenience of staff. The plaintiffs have been subjected to these conditions.

34. Aides and attendants are given great power and discretion to impose restrictions on the plaintiffs. Often this is done arbitrarily with no opportunity provided for appeal or review of such decisions.

35. Privileges (such as the opportunity to exercise outside), special events, and even some forms of therapy may be denied to plaintiffs for violations of Unit rules.

36. Unit rules include, inter alia, prohibitions against chewing gum, smoking, name-calling, visiting with parents or others in the dormitories.

37. The admission process includes a pre-admission contact or interview with a social worker and other staff (this may be the same day as admission) and an interview of the child by a psychiatrist, recorded in an admission note on the day of admission. The admission note summarizes the factual and psychiatric basis thought to justify the commitment.

Kevin S.

38. Plaintiff Kevin S. was admitted to Haverford State Hospital on July 18, 1977 pursuant to Section 201. He was born May 2, 1965. He was brought to the facility by his mother and the county child care agency.

39. A July 25, 1977 evaluation conducted by the school at which Kevin S. was in the fifth grade provides as a "diagnostic impression" of him:

> Kevin is a very needy, very angry boy who needs a supportive and consistent environment.

> He is not currently seen as psychotic although there is a tendency toward projection and a lack of controls when anxious. A behavior disorder of childhood is suggested. It should be noted, however, that the emergence of adolesence with its attendant conflicts and changes will in all likelihood, throw additional strains upon the defenses of an already disturbed child.

40. Kevin's mother is separated from her husband, who lives in New York. His brother, born in 1963, is in a foster home.

41. Kevin's mother has a history of serious mental illness and hospitalizations. She has also physically abused Kevin. As a result of these problems, most of Kevin's early life (he was born in a mental hospital) was spent in foster homes. Haverford State Hospital's psycho-social history describes the facts in this regard:

> She Kevin's mother has many schizophrenic-type features, such as tangential thinking, flight of ideas, inappropriate laughter and illogical statements. During the pre-admission interview there were several times when Kevin's response was much more appropriate than was his mother's. When we told the Squires that we could set an admission date, Mrs. Squires covered her face with her hands and made loud and wracking sobs for several seconds, then immediately stopped and, with no sign of emotion, exclaimed that Kevin's admission should be the sooner the better! This sort of behavior was rather inappropriate. However, she does have a caring for Kevin and expresses hope and a positive attitude that she and Kevin will be helped.

Reason for Hospitalization: Kevin was admitted on a voluntary 201a admission, signed by his mother, ———— S. Kevin has a history of much instability within the family. He was born in a state mental hospital, as his mother had requested admission there because she trusted the doctors. He was in a foster home for his first five months while his mother was in the state hospital. He subsequently was in another foster home for a few weeks, when he was seven years old (along with his brother), and again in 1971. He was in another foster home from August 1974, to May 1975, and in another home for a period of two years. Mrs. Squires would place the children because she physically abused them. She was having emotional and marriage difficulties and could not handle Kevin properly.

42. Shortly before his commitment to the institution, school authorities objected to his behavior there; he was allegedly making wierd noises, refusing to do work, and talking back to teachers. He was suspended from school. At home, his mother felt, he was hyperactive, and spent much time playing by himself.

43. During her fifteen years of marriage, Kevin's mother was in a mental hospital many many times; she attempted suicide twice before her children *was* born. As with Kevin, she was in a mental hospital when her elder son was born. When pregnant with Kevin, she returned to the hospital and, she told Haverford State Hospital staff, "lied" to get in again.

44. Kevin's brother, thirteen months his senior, had been in a foster home but at the time of Kevin's admission to Haverford was in a foster home in New York under the

custody of a county social services department. He too had been in a mental hospital.

45. The impression of the institution social worker was, "It is felt that much of Kevin's problems come from living with a schizophrenic mother and having a very unstable and confused early life." The social worker noted that Mrs. S actively uses social systems "to the point of abuse."

46. The decision to admit Kevin S. to the institution was made at a meeting at the hospital on July 13, 1977 with hospital staff and a representative of the county child care agency. An admission date of July 18, 1977 was set. No psychiatric report or evaluation was made during that pre-admission interview.

47. After he was admitted, on July 18, 1977, Dr. Mia Marcovici interviewed Kevins S. and filed the following "Admission Note:"

REASON FOR ADMISSION: Difficulties adjusting to school and family (mother). Exhibited bizarre behavior in school that has included making inappropriate sounds and laughing inappropriately.

MENTAL STATUS: (Use 2d page if necessary) Kevin is a 12 years, 2 month old boy who was accompanied to the hospital by his mother and Yol Sanders from the Delaware County Child Care Service. He was clean in his appearance and was generally cooperative. He had difficulty sitting still and concentrating on a topic. He was well oriented and spoke in short sentences. It appears that he spends a lot of time in his room building walls or playing with his cars. He has few friends and has difficul-

ties relating to peers. No thought disorder was elicited and denied hallucinations.

The "diagnostic impression" noted after this note was "Withdrawal Reaction of Childhood. 308.1."

48. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 2d Edition* (hereafter, "DSM-II") defines this diagnosis as follows:

> 308.1* Withdrawing reaction of childhood (or adolescence) *
>
> This disorder is characterized by seclusiveness, detachment, sensitivity, shyness, timidity, and general inability to form close interpersonal relationships.

49. There is no indication in the records of Kevin's admission to Haverford State Hospital of his comments or version of the behaviors he was accused of.

Richard S.

50. Richard S. is a Black youth, age 12, who was committed to Haverford State Hospital on June 6, 1966 pursuant to Section 201 by the county child care agency which had and has legal custody of him. He was born on September 24, 1964.

51. There had been a previous attempt to have him admitted to the Adolescent Unit of the same institution but he had not been accepted because of his size and age.

52. Richard S. did not live with his mother until he was two years old (he was under an agency's care) and lived with her at home only until he was four when

he was placed in the child care agency's Children's Cottage. He later lived in another institutional home for children and then at a residential school for difficult students, at which he was placed immediately prior to his commitment to the mental hospital.

53. Prior to his admission, a contact was made with the Haverford State Hospital at which the hospital authorities were told that Richard's problems included "running away from Silver Springs, putting glass in eye, striking resident while asleep, shaving head and breaking car windshield."

54. The staff of the school Richard was in recommended hospitalization to the child care agency which, in January, 1977, six months before his admission, wrote to Haverford seeking his commitment.

55. The first psychiatric evaluation recorded for Richard S. in the hospital records is dated June 6, 1977 by Dr. Miz Marcovicci and states as follows:

> REASON FOR ADMISSION: Inability to adjust to an open setting. History of self harm and running away.
>
> MENTAL STATUS: (Use 2d page if necessary) Ricky is a well developed, 12 year 8 month old boy. He is clean and neat in his appearance. He is well oriented in all three spheres. Ricky looks down to the floor most of the time. His eye contact is limited and he offers no spontaneous conversation. When asked questions he replies in short sentences. He is relevant and coherent. He appears preoccupied. No bizarre or inappropriate behavior was elicited. No restlessness or fidgitness was noticed. He has a

history of low impulse control, self harm, running away and unpredictable behavior.

The diagnostic impression was "Unsocialized Aggressive Reaction of Childhood."

56. This diagnosis is defined in the *DSM-II* as follows:

> 308.4* Unsocialized aggressive reaction of childhood (or adolescence) *
>
> This disorder is characterized by overt or covert hostile disobedience, quarrelsomeness, physical and verbal aggressiveness, vengefulness, and destructiveness. Temper tantrums, solitary stealing, lying, and hostile teasing of other children are common. These patients usually have no consistent parental acceptance and discipline.

57. The admission records at Haverford do not indicate Richard S's version of the behaviors of which he was accused. The only "self harm" indicated is the unexplained reference to "putting glass in eye."

58. Within a few days of admission, Richard S. expressed his desire to leave the institution; no attempt was made by institution staff to provide him with an attorney or to advise him of steps to take to obtain his release.

59. By October, 1977, his diagnosis was changed to "Withdrawing reaction of childhood", defined above.

60. The institution's doctor at Haverford prescribed the drug Thorazine to be administered by nurses, without further doctor's order, for any aggressive behavior.

James Paul M.

61. James Paul M. was born November 10, 1969 and was admitted at age 7 to Haverford State Hospital under Section 201 on October 17, 1977.

62. The admission note by Dr. Elizabeth Cheek states as follows:

> REASON FOR ADMISSION: Uncontrollable behavior. Learning disability.
>
> MENTAL STATUS: (Use 2d page if necessary) This eight year old youngster looked cheerful in the beginning but was clinging to the father later on. He was dressed in pair of jeans and a T-shirt. Speech was clear and understandable. There were no abnormalities of gait. Patient was sucking his thumb in the beginning and said, "I am not answering. My Dad will do." He used the phrase "Oh Brother" with a sigh for every sentence. Patient did not sit on a chair for more than 1 minute and changed toys very frequently. Patient was oriented to time, place and person. Pat have vague memories of past but was able to tell about recent things. He cannot remember the immediate things which were asked to repeat. He has short attention span, get frustrated with the toys very easily. Patient was not sure of the side? He did not like the idea of separating from father. Patient gets very anxious if he hears any voice outside. He feels that he should punch everybody if he cannot get things done. He sat very near the father later on.

The diagnostic impression was "Minimal brain dysfunction, learning disability." These diagnoses are not defined or listed in the *DSM-II*.

63. On his first day at the institution, the doctor prescribed the use of Thorazine. During Paul's first week, he was placed in a locked bare room alone, on an "as is necessary basis," on the discretion of non-medical staff.

64. Prior to this admission, Paul had been asked to leave school. At home all day, his behavior deteriorated. His mother died about a year ago. His father works all day.

Edward B.

65. Edward B., born October 26, 1965, was committed to Haverford State Hospital on May 9, 1977 by his father. He was referred to the institution by his psychiatrist who, it happens, is also a full-time psychiatrist in another unit at Haverford State Hospital.

66. Five days before admission, the referring psychiatrist and the parents of Edward B. reported to the social worker that the child had "acted out" at home and in the community. The only specific behavior reported or alleged was that he had thrown a rock through a "window that borders the school" in April, 1977.

67. At this pre-admission meeting, the parents further reported that

> they are policing the boy for fear of his running away, hurting self or others. They are quite concerned that an admission might be necessary when he comes for pre-admission 5/9/77 as they live in neighborhood, and the children call Haverford State Hospital a place for "retards or crazies." Neighbors are now suggesting that Ed is responsible for incidents of destruction in the neighborhood.

68. Edward is an adopted child.

69. The admission note by Ora Smith, M.D. of May 9, 1977 states:

> REASON FOR ADMISSION: Hyperactive with poor behavioral controls; threatens to hurt himself; feels depressed.
>
> MENTAL STATUS: (Use 2d page if necessary)
>
> This 11 year old boy is alert, oriented; and anxious and fearful about hospitalization. Has had a long history of disruptive behavior which is partially controlled by medications.

The "diagnostic impression" recorded in this note is as follows: "minimal brain dysfunction, adjustment reaction of childhood."

70. Minimal brain dysfunction is not defined in the *DSM-II*. Adjustment reaction of childhood is defined as follows:

> 307.1* Adjustment reaction of childhood*
>
> Example: Jealousy associated with birth of patient's younger brother and manifested by nocturnal enuresis, attention-getting behavior, and fear of being abandoned.

The *DSM-II* notes that this and certain other diagnoses are "transient situational disturbances" which "occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress."

71. During the many months of his commitment with a diagnosis indicating a short-term problem, the hos-

pital records and evaluations continued, each month, to state an "anticipated discharge date" of "three months." Paragraphs 84-86 below refer to this plaintiff.

Raymond C.

72. Raymond C., born September 9, 1964, was committed by his father to Haverford State Hospital at age 13 pursuant to Section 201.

73. He was referred to a local mental health clinic by his school. The mental health clinic referred him to Haverford State Hospital for residential treatment evaluation.

74. Raymond C., at the time of his admission, was under the jurisdiction of the Juvenile Court, with a background of stealing minibikes.

75. He was admitted to Haverford State Hospital the day he was first seen at that facility.

76. The admission note, dated September 28, 1977, and reflecting the examination performed on the day of Raymond's admission, states:

> REASON FOR ADMISSION: History of uncooperative disruptive and aggressive behavior including run away from school. Problems in community with stealing and destroying property. Has a learning and hearing problem—Admission and evaluation to assist in future planning to meet his needs.
>
> MENTAL STATUS: (Use 2d sheet if necessary) An alert, sad and anxious immature looking 13 year old. Patient avoids (refuses) any conversation with adults other than his parents. He does not evidence any overt physical deficits other than hearing. He does not display anything suggestive or psychosis. His lack of cooperation at this time prevents doing a desirable mental status examination.

The diagnostic impression was one of a "behavior disorder of childhood" and a non-psychotic organic brain syndrome with associated speech, hearing and learning disabilities.

77. Raymond C.'s father had a drinking problem. He died on or about October 30, 1977.

William B.

78. Nine years old, William B. was born on June 18, 1968 and was committed to Haverford State Hospital by his father, pursuant to Section 201, on September 21, 1977.

79. William's parents had separated and divorced when he was an infant. About two years prior to his commitment, he began living with his natural father in a home with his stepmother and two stepbrothers.

80. The admission note by Dr. Mia Marcovicci states:

> REASON FOR ADMISSION: Uncontrollable behavior; preoccupied with matches, set a rug on fire, turned the gas burners on in the house, throws things out the window.
>
> MENTAL STATUS: (Use 2d page if necessary) This 9 years, 3 months old boy was referred to Haverford State Hospital by Media Child Guidance Clinic and Dr. Fittie. He has been in therapy for the past few months and recently his behavior has

deteriorated. He turned on gas burners in the house, smears feces and has taken away and hid his youngest brother's injectible medication for allergies (the desensitize lotion vaccine)

Billy is well developed and neat in his appearance. He exhibited no separation anxiety from his parents and was spontaneous and talkative. He talked about the boy in his head who tells him to do bad "things". He claims to hear his voice but did not see him. He was restless, anxious and destructible. He exhibited some inappropriate behavior in the office. Billy is well oriented and coherent.

The diagnostic impression was "overanxious reaction of childhood".

81. This diagnosis is defined in the *DSM-II* as follows:

308.2* Overanxious reaction of childhood (or adolescence) *

This disorder is characterized by chronic anxiety, excessive and unrealistic fears, sleeplessness, nightmares, and exaggerated autonomic responses. The patient tends to be immature, self-conscious, grossly lacking in self-confidence, conforming, inhibited, dutiful, approval-seeking, and apprehensive in new situations and unfamiliar surroundings.

82. William B.'s life with family members subjected him to a situation of extreme inconsistency, disorganization and lack of structure. His natural mother's lifestyle was erratic and she reportedly abused him. His grandparents have given him affection but their handling of him has also been destructive to his development.

83. His mother and his grandparents were not told of the plans for his commitment; they were informed after he was institutionalized.

Edward B., Further Facts (see paragraphs 65-71 above)

84. Eddie B. was admitted to Haverford State Hospital on May 9, 1977, by his parents, very upset, as he had been tricked into going by his parents. He was committed under Section 201.

85. The admission note indicates the facts surrounding his entry into the institution:

From the beginning, Eddie was extremely upset and crying. He was totally unprepared for admission to a hospital. On the way, his parents told him they were taking him to a new school as he could not continue in his present one. Mrs. B. ——— explained that this problem had existed for some time but that he had not been excluded until recently because she was a teacher in that setting and the school had permitted him to remain. To prevent misunderstanding of why he was here, it was pointed out that this was a hospital and that school was a part of the program rather than the primary reason for the children coming. Because Eddie was so upset, I suggested that one of the teachers tell him a little about our school so that he could know this part of the program. Although this was done, Eddie heard very little about what was said because of the way he had been brought for this admission.

Eddie then opened up with many feelings about being tricked into coming by his parents. He ex-

> pressed feelings about them not caring for him and wanting to get rid of him. Both parents acknowledge that they had "tricked him" because they were fearful he would hurt or threaten to hurt himself. They admitted that they had not told him until that morning and had omitted the fact that this was a psychiatric hospital. Eddie's response to this was to make promises that he would change if he could stay home. * * * Eddie continued with his fears of being in a "crazy" hospital and of getting hurt by other patients—both adults and children. He also spoke of the high fences and of being kept in, like a prisoner. * * *

During this admission interview, Eddie was told he would not be permitted home for a home visit for three weeks to a month. He responded, "My God, you're trying to kill me." To comfort him, the doctor suggested that he could go on a trip the next day with the other children. His parents interjected that they did not trust that he would not run away. The doctor then agreed that he would not go on the trip.

86. Eddie was not told during this admission process that the institution would help him obtain a lawyer or any legal assistance.

Francis B.

87. Francis B., born January 9, 1967, was 9½ years old when he was admitted to Haverford State Hospital on August 16, 1976 pursuant to Section 403 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. 4403.

88. This admission was at the request of his father who signed admission forms which were not filled out,

which did not list the son's full name (or, on the Section 403 form, any name at all) or any identifying information whatsoever. On September 7, 1976, the father executed a form under the successor statute, Section 201, asking the hospital to commit Francis B. for care and agreeing that the hospital need not release Francis B., even at the father's request, without at least 72 hours notice.

89. Francis B. comes from a disorganized family which has rejected him. As a social history a month before his commitment indicates, "One of the most distressing aspects of this case is the almost total rejection of Frankie by everyone in his family." His father has a drinking problem, the records indicate that the "parents are in need of help also as there is some question here of physical abuse" and, at the pre-admission interview at Haverford, it was apparent that "Frank could no[t] do right in parent's eyes." There are five children in the family, all boys.

90. The admission note of August 16, 1976 by Dr. Mia Marcovicci which records the psychiatric justification for the commitment notes "difficulties adjusting to school" and that Francis B. "has been described as hyperactive . . . clowning in order to get attention." The diagnostic impression was of "Unsocialized aggressive reaction of childhood," a term the official definition of which is noted above at Paragraph [56].

91. After Francis B. was committed, the institution received background an referral material including a psychiatric evaluation which indicated that "The school seems to tolerate this boy fairly well" and that, despite the "hyperactivity" attribution, "I cannot describe him

as hyperactive. In the first interview his mother seemed more hyperactive than he did."

Maria L.

92. Maria L., born August 26, 1965, was committed to Haverford State Hospital on April 25, 1977 by her mother pursuant to Section 201.

93. The admission note by Dr. Mia Marcovicci states as follows:

> REASON FOR ADMISSION: Difficulties adjusting to school because of aggressive behavior. Difficulties adjusting within the family.
>
> MENTAL STATUS: (Use 2d sheet if necessary) Maria is a 11 year 7 month old girl who came today accompanied by her mother. She speaks freely about her aggressive behavior in school and describes the fights she gets into. She does not respond to limits at home.
>
> She is restless and fidgity. She is well oriented and relates well to the examiner. No bizarre or inappropriate behavior was elicited. She claims that she will miss her brother Danny (suffers from muscular dystrophy) because "we get in trouble together". She does not appear remorseful about her behavior.

The diagnostic impression was "Unsocialized Aggressive Reaction of Childhood. 308.4"

94. Maria L. has resisted the regimentation and directions imposed upon her by the institutional staff; one staff note quotes her as saying, during a meeting with staff and her mother, "I don't have to listen to these staff people, they're not my parents."

Thomas W.

95. Thomas W. was committed to Haverford State Hospital on an emergency commitment which was later changed to a commitment under Section 201. He was institutionalized at that facility on June 2, 1977.

96. Born February 14, 1966, Thomas' parents have an unstable marriage. After a severe beating which resulted in his hospitalization in 1975, Thomas' case came to the attention to social service agencies and his mother and stepfather were arrested.

97. The county child care agency, which has custody of Thomas W., committed him to Haverford from the County Juvenile Detention Center where he allegedly broke a large window, assaulted a staff member and set several small fires.

98. The admission note for Thomas W. states the basis the facility used for his commitment:

> REASON FOR ADMISSION: Fire setting, rages of 5-6 hours, during which he is assaultive, destructive and sets fires.
>
> MENTAL STATUS: (Use 2d page if necessary) Patient is a good looking 11 year old black male who is well dressed. He rapidly became angry as I asked him questions. He admits to fire setting and destructive behavior "because they get on my nerves . . . . they get me mad." He appeared quite bright and was adept at standing up for himself. He has been evicted from school for allegedly exhibiting himself and for sexual behavior toward girls. It is also claimed that he has been involved in sexual behavior with his three year old sister and girls in the

neighborhood. He denied any sexual behavior except with a nine year old neighbor girl. He denied insomnia, anorexia, depression and self-destructive ideation. He said that the only person he trusted in his family was his three year old sister.

Child Care Worker says he's repeatedly run away, goes into rages of 5-6 hours, has demolished dresser drawers and several windows, pulled a knife on a cottage staff member, has repeatedly been assaultive and was reported to be grunting and evoking unintelligible verbage last night at the detention center. He has repeatedly complained that he has asthma, chest pain and liver trouble but physical was negative.

99. Scapegoated in the home, the professionals involved in his case feel, Thomas acts out the marital and family conflict in his daily life.

100. On May 31, 1977, just two days prior to his commitment to Haverford, Thomas W. was given a psychiatric evaluation by Dr. John Fong, a defendant in this action. Dr. Fong evaluated Thomas W. not as superintendent of Haverford State Hospital but, at the request of a county judge, in his capacity as consultant to the court. He found the child to be non-psychotic but dangerous. He also found that Thomas W. disputed many of the behaviors he was accused of and explained that some were a response to mistreatment. Dr. Fong recommended family therapy, having been informed that admission was being arranged to a private facility. Haverford State Hospital information at the time of Thomas W.'s commitment, however, erroneously stated that Dr. Fong recommended admission. Despite the involvement of the

juvenile court and its jurisdiction over Thomas, no court hearing or judicial authorization for the commitment was ever sought or authorized.

Pennhurst State School and Hospital; Polk State School and Hospital

101. Pennhurst State School and Hospital is located in a rural area of Pennsylvania near Valley Forge. Built in the first decade of this century, it is a overcrowded and understaffed institution, unaccredited by the Joint Commission on Accreditation of Hospitals. Residents generally receive little habilitative programming. Institutional life for Pennhurst residents is regimented and unpersonalized. The facility houses about 1200 people. The institution and its staff are defendants in *Halderman v. Pennhurst State School and Hospital*, Civil Action Number 74-1345 (E.D. Pa., Tried April-June, 1977, pending decision).

102. Polk State School and Hospital is located in the rural community of Polk, Pennsylvania, approximately 80 miles from Pittsburgh. It is not served by any public transportation. Now housing about 1700 residents, its rated bed capacity is 1321. Polk was built 80 years ago in 1897; those ancient buildings continue to house the plaintiffs in large dormitory areas, residents sleeping head to head. The institutional conditions are regimented and unpersonalized.

Gina S.

103. Gina S. was committed to Polk State School and Hospital on October 20, 1970 by her mother pursuant to Section 404 of the Mental Health and Mental Retardation Act of 1966, which permitted any two doctors to commit any person upon the certification of said doctors.

104. This statute, Section 404, was declared unconstitutional in 1971 in *Dixon v. Attorney General of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971) (Three-Judge Court).

105. No legal commitment papers were executed from 1971 until November 25, 1975 (during which time Gina S. remained at Polk) when the plaintiff's mother applied to the defendant director of the institution for plaintiff's commitment under Section 402 of the Mental Health and Mental Retardation Act of 1966.

106. At the age of 6, in 1967, the year her parents were divorced, Gina S. was placed in a county "infants' home." Three years later, in 1970, she was removed by her mother and taken directly to Polk where she has remained since.

107. The certificates of the doctors certifying the need for commitment stated as follows:

a. Certificate No. 1:

(History of illness) Mongolism since birth with moderate retardation.

(Physical and Mental Findings at Time of Examination) Px as noted. Has limited speech. Child can handle most personal care. She has (illegible) heart disease.

b. Certificate No. 2:

(History of illness) Down's Syndrome—moderate retardation. Fair speech and recognition.

(Physical and Mental Findings at Time of Examination) Typical mongoloid features with high palate, small fifth digit; also with gingival hypertrophy, loud systolic m.

108. The report of the psychologist which accompanied the doctor's reports reported the facts of her condition as follows:

(Maturation) Gina is an affectionate and alert little girl of moderate mongoloid appearance. Motor development appears adequate, and she was able to deal with all tasks presented from this standpoint.

(Social Adjustment) Gina was cooperative in the test setting, sitting quietly but responsive to the examiner's questions. Her speech was hard to understand although some single words were very distinct.

(Names of Tests and Results) Stanford-Binet, form L-M: CA: 9-2; MA: 3-4; IQ: 35.

Gina is functioning in the moderately mentally retarded range of intelligence. She can respond well to concrete verbal direction, and is able to use language denotively.

(Diagnosis) Mongolism, AAMD Classification: 64.

Nancy Louise D.

109. Nancy Louise D. was born in 1960, Both her parents were alcoholics. Both her parents were mentally retarded.

110. In 1961, Nancy Louise war adjudicated a neglected child and placed under the guardianship of the county welfare department which placed her in foster care until May 22, 1968 when she was taken directly from foster care to Polk State School and Hospital.

111. On April 12, 1968, the county welfare director executed an application to the defendant director of Polk for the commitment of Nancy Louise to Polk. This was done under the Pennsylvania Mental Health Act of 1951 (*not* the 1966 Act). The child was committed on May 22, 1968.

112. No commitment forms have ever been executed under the Mental Health and Mental Retardation Act of 1966 by the guardian or by anyone else.

113. The defendant director of Polk purports to maintain the confinement of the plaintiff pursuant to Section 402 of the Mental Health and Mental Retardation Act of 1966.

114. The basis for commitment, as described in a physician's certificate attached to the 1968 application is as follows:

> (History of Illness) At age 3½ there was marked retardation—did not walk or talk—began walking at about 4½ years.
>
> (Physical and Mental Findings at Time of Examination) Psych. reports will be submitted—obviously retarded—Physical examination essentially neg. except for poor muscular coordination.

George S.

115. George S., abandoned by his parents, was placed at an early age in the custody of the Philadelphia Welfare Department which, by contract, arranged for Catholic Social Services to provide for his care.

116. Catholic Social Services placed him from the first year of his birth until 6 years later (when he was committed to Pennhurst) with a foster family, Mr. and Ms. C.

117. In 1969, the foster mother was hospitalized and, after her discharge, was temporarily not able to resume care of George. As a temporary measure, George was placed in another foster home; however, because of the crowded conditions in that home, the placement could not be maintained. Catholic Social Services, on behalf of the county welfare department, then applied for and was granted commitment to Pennhurst for a short-term period of 90 days.

118. The days lengthened into years; no placement outside Pennhurst was arranged or obtained despite the fact that George could function in a non-institutional setting.

119. George's foster mother, Ms. S., has maintained continual contact with him, and attempted to regain care of him, only to be rebuffed by the institution and the welfare department, for no proper reason.

120. During his commitment at Pennhurst, George has suffered numerous bites, scratches and other injuries. On one ward where he lived, he was frequently tied to a bench; he would attempt to walk anyway, dragging the bench after him. Until the last year before the lawsuit referred to in Paragraph 121 was filed, George was constantly naked or wearing clothes that were not his; he never wore shoes or stocks on the bare concrete floors of the ward. Pennhurst officials told the foster mother that they medicated George to keep him quiet. On medication, he would sit and rock, his eyes glassy and his attitude sleepy. Off drugs, he is fine and plays and relates to the world.

121. George S. is a plaintiff in *Halderman v. Pennhurst State School and Hospital,* C.A. No. 74-1345, brought to trial in April-June, 1977.

The Statutory Scheme for the Mentally Ill

122. Subclass A, plaintiffs alleged to be mentally ill, are confined to institutions pursuant to Section 201 of the Mental Health Procedures Act of 1977, hereafter, "Section 201." This law became effective September 7, 1976.

123. Section 201, in relevant part, states:

> A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child.

124. There is no time limitation on the length of a commitment under Section 201.

The Statutory Scheme for the Mentally Retarded

125. The members of Subclass B are confined to institutions pursuant to Sections 402 and 403 of the Mental Health and Mental Retardation Act of 1966, hereafter, Sections 402 and 403, under a scheme described and dealt with by the Court in the earlier phase of this litigation.

126. Sections 402 and 403 provides that applications for admission/commitment may be made by:

> A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

Section 402(a)(2); Section 403(a)(2) (identical language in both sections).

127. There is no time limitation on the length of commitments under Sections 402 and 403.

Commitments of Other Persons in Pennsylvania

128. Aside from the members of the plaintiff class, other persons committed to Pennsylvania institutions for the mentally ill and the mentally retarded do so either voluntarily on their own personal volition or for short-term emergency care or after a judicial hearing at which they have the rights to notice, appointed counsel, presentation of testimony in their own behalf, confrontation and cross-examination of adverse witnesses, expert assistance, court-ordered outpatient or partial hospitalization instead of in-hospital commitment. Many juveniles are committed under the statutory provisions guaranteeing such procedural protections, including juveniles in plaintiffs' situations.

Department of Public Welfare Regulations

129. On September 1, 1973, during the pendency of this lawsuit, the defendants adopted regulations regarding the commitment of juveniles, published in volume 37, Pennsylvania Bulletin (Sept. 1, 1973). These regulations continue to apply to Subclass B, the plaintiffs who are persons with retardation. These regulations *do not apply* to Subclass A, those persons committed under Section 201, as allegedly mentally ill.

130. The three plaintiffs technically subject to these regulations are totally unable to benefit thereby, as they are unable to understand the rights stated therein or to exercise them. The applicants for admission (two welfare agencies and a parent) have not and will not utilize those provisions to secure these plaintiffs' rights.

Previous Hospitalization

131. Absolutely none of the named plaintiffs in this action have received mental hospitalization prior to the commitments to the institutions in which they are now confined.

Family Disorganization

132. Families seeking commitment of allegedly handicapped children are characterized by severe stress, dislocation and disharmony. The problems of children are a function of intrafamilial problems and exist in a context of a weakened family structure, with conflict overtly expressed.

133. The juvenile behavior which precipitates institutionalization may be provoked by the parents; there are also many cases where the child may be driven to such behavior by the conflicts in the home.

134. Parents will often seek to institutionalize children for improper reasons. This stems from honest mistakes or ignorance or sometimes from malice or ill will. In a significant number of cases, the parental purpose of bringing a child to residential treatment has been to accuse, punish and separate the child from the home. The motivation is not always good.

135. Parents are not particularly good observers of children's behavior and symptoms and, especially in the context of the high feelings that run in situations of conflict, parents are not reliable sources of factual information about the child and his or her behavior.

136. Parents who bring their children to psychiatrists for care cannot be objective reporters of the behavioral background of the child. They often exaggerate and misinterpret the actions of their children and may often react antagonistically to their children.

Effects of Institutionalization

137. Institutionalization is a severe deprivation of one's liberty and may be extremely harmful, resulting in what one of the state's witnesses at trial called "an emotional deficiency disease." Barton, *Institutional Neurosis* (2d Ed. 1966); Goffman, *Asylums* (1961); Belknap, *Human Problems of State Mental Hospitals* (1956); Stanton and Schwartz, *The Mental Hospital* (1954); Wing and Brown, *Institutionalization and Schizophrenia* (1970); Vail, *Dehumanization and the Institutional Career* (1966).

138. Institutionalization for mental handicap results in severe social stigma, self-stigmatization, employment and license discrimination and liabilities.

139. In a practical sense, institutionalization may make treatment difficult because of the difficulty in involving the family in treatment and the fact that an institutional setting is less likely to be oriented toward family pathology. As one expert testified on the general ill effects of institutions, "We have to be cognizant of the enormous social toll that institutionalization brings."

Reliance on Psychiatrists Would Be Misplaced

140. The mentally retarded should not be in institutions at all.

141. Psychiatrists can and do err and disagree in making diagnoses and recommendations for institutionalization of plaintiffs.

142. As children who are most likely to be institutionalized are in the lower class, the psychiatrists who evaluate them are at a great distance culturally, class-wise and geographically from the situation in which the children are living, and thus the psychiatrists misperceive behavior.

143. Psychiatric evaluations for commitment are short and not conducted over a sufficient period of time. Children are often referred for hospitalization without exploration of less restrictive alternatives. Over crowded clinics may overrecommend institutionalization.

144. In the stress of the admission interview, a juvenile may not present an accurate picture of his or her mental status and may appear in worse condition than is actually the case.

145. There is pressure on the institutional doctor to agree with any referring psychiatrist's recommendation for institutionalization; the needs of the institution will inevitably affect admission decisions of institutional doctors; the information that largely influences the doctor's decision to commit comes from the parents and any referring psychiatrist.

146. Some psychiatrists may start with a presumption that the person before them is mentally disturbed, thereby leading to a skewed interpretation of the picture presented.

147. Improper evaluations may result from countertransference due to which the psychiatrist may become unable to recognize or to explore the patient's conflict in some situations.

148. There is a tremendous conflict of interest created when psychiatrists are permitted to make institutionalization decisions.

149. Present law permits parents to doctor-shop for doctors who will agree to commit their child.

150. The considerations detailed above apply as well to the mentally retarded.

Factual Basis of Need for Hearing

151. Because of their immaturity and lack of experience, it is even more important that juveniles receive the protection of a hearing than adults. This is especially true of those persons under 14, who are severely limited in their ability to speak for themselves and of the retarded 18 and under.

152. Assistance of counsel is essential and can help treatment of juveniles and can in no significant way hinder such treatment.

153. Hearings would not be unduly traumatic for juveniles and would not interfere with treatment or the parent-child relation. To the contrary, a hearing would encourage more appropriate resolution of problems and would have a positive and beneficial effect on the child.

154. The opportunity for hearings would not discourage people from seeking treatment for juveniles, but would result in agencies and psychiatrists performing more effectively and in the avoidance of the necessity of hearings in many cases.

VIII. CAUSE OF ACTION

155. By operation of Section 201 and Sections 402 and 403, plaintiffs and their class are detained and incarcerated involuntarily in mental institutions without the right to notice, the right to a hearing or hearings, the right to counsel and, if indigent, appointment of counsel, the right to present evidence and testimony on their own behalf, the right to subpoena witnesses and documents, the right to confront and cross-examine witnesses against them and those who wish them to be committed, the right to independent expert examination and assistance, the right to be involuntarily detained only upon the decision of a disinterested and impartial decision-maker, the right to appeal, other procedural safeguards.

156. By operation of the said statutes, and by defendants' actions in operating, enforcing and executing the same, plaintiffs and their class are deprived of their life, liberty and property without Due Process of Law in violation of the Fourteenth Amendment to the United States Constitution.

IX. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray, on behalf of themselves and all others similarly situated, that this Honorable Court:

1. Continue jurisdiction of this cause, and the already-convened three-judge court, and set this case promptly for an expedited hearing;

2. Determine by order, pursuant to Rule 23(c) (1) that this action be maintained as a class action;

3. Enter a final judgment, pursuant to 28 U.S.C. 2201 and 2202 and Rule 57 of the Federal Rules of Civil Procedure declaring that the challenged statutes are invalid, void and of no effect on the ground that they violate the Fourteenth Amendment to the United States Constitution;

4. Enter preliminary and final injunctions enjoining defendants from enforcing and executing such statutory provisions;

5. Allow plaintiffs and the guardian ad litem their costs herein and reasonable attorney and guardian ad litem fees;

6. Grant such additional and alternative relief as may be deemed by the Court appropriate, just, proper and equitable.

Respectfully submitted,

(s) David Ferleger
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for Plaintiffs

November 2, 1977

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA
[Caption Omitted in Printing]
ANSWER

First Defense

1. PARAGRAPH ONE (1) contains legal conclusions to which NO RESPONSES are required. However, if they are deemed factual in nature they are denied.

2. PARAGRAPH TWO (2) is ADMITTED to the extent that it characterizes the form of the action and the manner in which it is brought; all remaining averments are denied.

3. PARAGRAPH THREE (3) is ADMITTED to the extent that it avers that the defendants are responsible for the custody of the plaintiffs. The characterization of the custody as "involuntary" is a LEGAL CONCLUSION to which NO RESPONSE is required. However, if it is deemed factual in nature, it is denied.

4. PARAGRAPH FOUR (4) is ADMITTED.

5. PARAGRAPH FIVE (5) is ADMITTED to the extent that it purports to characterize the jurisdictional base of this action.

6. PARAGRAPH SIX (6) is ADMITTED to the extent that it purports to characterize the jurisdictional base of the action. The remaining averment, that defendants acted under color of state law, constitutes a LEGAL CONCLUSION to which no response is required. However, if it is deemed factual in nature, it is DENIED.

7. PARAGRAPH SEVEN (7) is ADMITTED to the extent that it purports to set forth the statutes and Federal Rules authorizing plaintiffs' claims for relief.

8. PARAGRAPH EIGHT (8) constitutes a LEGAL CONCLUSION to which NO RESPONSE is required.

9. PARAGRAPH NINE (9) is ADMITTED to the extent that it purports to characterize the form of this action.

10. PARAGRAPH TEN (10) is ADMITTED to the extent that it purports to describe the proposed plaintiff class.

11. PARAGRAPH ELEVEN (11) is DENIED.

12. PARAGRAPH TWELVE (12) is DENIED.

13. PARAGRAPH THIRTEEN (13) is ADMITTED to the extent that it purports to set forth the questions of law and fact involved in this action.

14. PARAGRAPH FOURTEEN (14) is ADMITTED.

15. PARAGRAPH FIFTEEN (15) is ADMITTED to the extent that it avers the manner in which the plaintiffs bring this action, all remaining factual averments are DENIED.

16. PARAGRAPH SIXTEEN (16) is ADMITTED.

17. PARAGRAPH SEVENTEEN (17) is ADMITTED.

18. PARAGRAPHS EIGHTEEN (18) through THIRTY-FIVE (35) are ADMITTED.

26. (Numbered incorrectly in Complaint) PARAGRAPH TWENTY-SIX (26) (page 7 of Complaint) is ADMITTED except that it is DENIED that the plaintiffs' parents "volunteered" the plaintiffs into Haverford State Hospital.

27. (Numbered incorrectly in Complaint) PARAGRAPH TWENTEY-SEVEN (27) (page 7 of Complaint) is ADMITTED.

28. (Numbered incorrectly in Complaint) PARAGRAPH TWENTY-EIGHT (28) (page 7 of Complaint) is ADMITTED except that it is DENIED that "[a]long the hallway are two bare unfurnished rooms. . . .".

29. (Numbered incorrectly in Complaint) PARAGRAPH TWENTY-NINE (29) (page 7 of Complaint) is ADMITTED.

30. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY (30) (page 8 of Complaint) is ADMITTED.

32. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY-TWO (32) (page 8 of Complaint) is DENIED.

33. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY-THREE (33) (page 8 of Complaint) is DENIED.

34. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY-FOUR (34) (page 8 of Complaint) is DENIED.

35. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY-FIVE (35) (page 8 of Complaint) is DENIED.

36. PARAGRAPH THIRTY-SIX (36) is ADMITTED.

37. PARAGRAPH THIRTY-SEVEN (37) is ADMITTED.

38. PARAGRAPH THIRTY-EIGHT (38) is ADMITTED.

39. PARAGRAPH THIRTY-NINE (39) is ADMITTED.

40. PARAGRAPH FORTY (40) is ADMITTED except it is DENIED that Kevin's brother is in a foster home.

41. PARAGRAPH FORTY-ONE is DENIED.

42. PARAGRAPHS FORTY-TWO (42) and FORTY-THREE (43) are ADMITTED only to the extent that they accurately summarize certain portions of Kevin S's official records at Haverford State Hospital.

44. PARAGRAPH FORTY-FOUR (44) is ADMITTED.

45. PARAGRAPH FORTY-FIVE (45) is DENIED as it is an incomplete and therefore inaccurate reference to certain portions of Kevin S.'s official records at Haverford State Hospital.

46. PARAGRAPH FORTY-SIX (46) is ADMITTED to the extent that it avers that the decision to admit Kevin S. to Haverford was made on July 13, 1977, and that an admission date of July 18, 1977 was established. All remaining averments are DENIED.

47. PARAGRAPH FORTY-SEVEN (47) is ADMITTED.

48. PARAGRAPH FORTY-EIGHT (48) is DENIED as being incomplete and therefore inaccurate.

49. PARAGRAPH FORTY-NINE (49) is DENIED.

50. PARAGRAPH FIFTY (50) is DENIED.

51. PARAGRAPH FIFTY-ONE (51) is DENIED.

52. PARAGRAPH FIFTY-TWO (52) is ADMITTED only to the extent that it accurately summarizes certain portions of Richard S.'s official records at Haverford State Hospital.

53. PARAGRAPH FIFTY-THREE (53) is DENIED.

54.-55. PARAGRAPHS FIFTY-FOUR (54) and FIFTY-FIVE (55) are ADMITTED.

56. PARAGRAPH FIFTY-SIX (56) is DENIED as being incomplete and therefore inaccurate.

57.-58. PARAGRAPHS FIFTY-SEVEN (57) and FIFTY-EIGHT (58) are DENIED.

59. PARAGRAPH FIFTY-NINE (59) is ADMITTED.

60. PARAGRAPH SIXTY (60) is DENIED.

61.-62. PARAGRAPHS SIXTY-ONE (61) and SIXTY-TWO (62) are ADMITTED.

63. PARAGRAPH SIXTY-THREE (63) is DENIED.

64. PARAGRAPH SIXTY-FOUR (64) is ADMITTED only to the extent that it accurately summarizes

certain portions of Richard S.'s official records at Haverford State Hospital.

65. PARAGRAPH SIXTY-FIVE (65) is ADMITTED except that it is DENIED that Edward B.'s psychiatrist is "also a full-time psychiatrist in another unit at Haverford State Hospital".

66.-67. PARAGRAPHS SIXTY-SIX (66) and SIXTY-SEVEN (67) are DENIED as incomplete and therefore inaccurate summaries of certain portions of Edward B.'s official records at Haverford State Hospital.

68.-69. PARAGRAPHS SIXTY-EIGHT (68) and SIXTY-NINE (69) are ADMITTED.

70. PARAGRAPH SEVENTY (70) is DENIED as being incomplete and therefore inaccurate.

71. PARAGRAPH SEVENTY-ONE (71) is DENIED except that it is ADMITTED that paragraphs 84-86 refer to this plaintiff.

72. PARAGRAPH SEVENTY-TWO (72) is ADMITTED except that it is DENIED that Raymond C. was committed by his father to Haverford State Hospital.

73. PARAGRAPH SEVENTY-THREE (73) is ADMITTED.

74. PARAGRAPH SEVENTY-FOUR (74) is DENIED.

75.-76. PARAGRAPHS SEVENTY-FIVE (75) and SEVENTY-SIX (76) are ADMITTED.

77. PARAGRAPH SEVENTY-SEVEN (77) is DENIED.

78.-80. PARAGRAPHS SEVENTY-EIGHT (78) through EIGHTY (80) are ADMITTED.

81. PARAGRAPH EIGHTY-ONE (81) is DENIED as being incomplete and therefore inaccurate.

82. PARAGRAPH EIGHTY-TWO (82) is ADMITTED only to the extent that it accurately summarizes certain portions of William B.'s official records at Haverford State Hospital.

83. PARAGRAPH EIGHTY-THREE (83) is DENIED in that the defendants are without knowledge or information sufficient to form a belief as to the truth of the averments contained therein.

84.-85. PARAGRAPHS EIGHTY-FOUR (84) and EIGHTY-FIVE (85) are DENIED.

86.-87. PARAGRAPHS EIGHTY-SIX (86) and EIGHTY-SEVEN (87) are ADMITTED.

88. PARAGRAPH EIGHTY-EIGHT (88) is DENIED.

89.-90. PARAGRAPHS EIGHTY-NINE (89) and NINETY (90) are ADMITTED only to the extent that they accurately summarize certain portions of Francis B.'s official records at Haverford State Hospital.

91. PARAGRAPH NINETY-ONE (91) is DENIED.

92.-93. PARAGRAPHS NINETY-TWO (92) and NINETY-THREE (93) are ADMITTED.

94. PARAGRAPH NINETY-FOUR (94) is DENIED as being incomplete and therefore inaccurate.

95. PARAGRAPH NINETY-FIVE (95) is ADMITTED.

96.-97. PARAGRAPHS NINETY-SIX (96) and NINETY-SEVEN (97) are ADMITTED only to the extent that they accurately summarize certain portions of Thomas W.'s official records at Haverford State Hospital.

98. PARAGRAPH NINETY-EIGHT (98) is ADMITTED.

99. PARAGRAPH NINETY-NINE (99) is DENIED.

100. PARAGRAPH ONE HUNDRED (100) is DENIED.

101. PARAGRAPH ONE HUNDRED AND ONE (101) is DENIED except that it is ADMITTED that Pennhurst State School and Hospital is located in a rural area of Pennsylvania near Valley Forge, and that it originated in the first decade of this century and is currently unaccredited by the Joint Commission on Accreditation of Hospitals.

102. PARAGRAPH ONE HUNDRED AND TWO (102) is ADMITTED to the extent that it avers that Polk State School and Hospital is located in the rural community of Polk, Pennsylvania, approximately 80 miles from Pittsburgh and originated in 1897. All remaining averments are DENIED.

103.-116. PARAGRAPHS ONE HUNDRED AND THREE (103) through ONE HUNDRED AND SIXTEEN (116) are ADMITTED only to the extent that they accurately summarize certain portions of the specified plaintiffs' official records at Polk State School and Hospital.

117. PARAGRAPH ONE HUNDRED AND SEVENTEEN (117) is ADMITTED only to the extent that it accurately summarizes certain portions of George S.'s official records at Pennhurst State School and Hospital except that it is denied that Catholic Social Services was granted a "commitment to Pennhurst for a short-term period of 90 days."

118. PARAGRAPH ONE HUNDRED AND EIGHTEEN (118) is DENIED.

119.-120. PARAGRAPHS ONE HUNDRED AND NINETEEN (119) and ONE HUNDRED AND TWENTY (120) are DENIED.

122.-129. PARAGRAPHS ONE HUNDRED AND TWENTY-TWO (122) through ONE HUNDRED AND TWENTY-NINE (129) constitute legal conclusions and therefore require NO RESPONSES.

130. PARAGRAPH ONE HUNDRED AND THIRTY (130) is DENIED.

131. PARAGRAPH ONE HUNDRED AND THIRTY-ONE (131) is ADMITTED.

132.-156. PARAGRAPHS ONE HUNDRED AND THIRTY-TWO (132) through ONE HUNDRED AND FIFTY-SIX (156) constitute legal conclusions and therefore require NO RESPONSE, if however, they should be deemed factual in nature, they are DENIED.

Second Defense

Plaintiffs' claims must be dismissed inasmuch as there is not sufficient "state action" to implicate the Due Process Clause of the Fourteenth Amendment.

Third Defense

Plaintiffs have failed to state a claim for which relief may be granted.

Fourth Defense

This Court lacks jurisdiction over the subject matter of this action.

Fifth Defense

The classes proposed by plaintiff should not be allowed in that juveniles who have been admitted by publice welfare agencies cannot adequately represent those unnamed juveniles who have been admitted by their parent or parents.

Sixth Defense

This case should not be maintained as an action against a class of defendants.

Seventh Defense

Plaintiffs have failed to exhaust adequate statutory remedies available to them under state law.

WHEREFORE, defendants request that the complaint be dismissed and that judgment be entered in their favor.

(s) Norman J. Watkins
NORMAN J. WATKINS
Deputy Attorney General
ROBERT B. HOFFMAN
Assistant Attorney General
J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation
ROBERT P. KANE
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

MOTION FOR CLASS ACTION

Plaintiffs, by their attorney and guardian ad litem, hereby move the Court to declare this a class action, pursuant to Rule 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure and to allow it to be maintained on behalf of the following class and subclasses of plaintiffs and against the following class of defendants:

Plaintiff Class and Subclasses:

The members of the class of plaintiffs are all persons who are or who may be committed to institutions for the mentally ill and the mentally retarded in Pennsylvania upon application of parents or guardians and without notice, hearing, counsel and other procedural safeguards.

Subclass A of plaintiffs includes all those persons under 14 years of age committed under Section 201 of the Mental Health Procedures Act of 1976.

Subclass B of plaintiffs consists of all persons 18 years of age or younger committed under Sections 402 and 403 of the Mental Health and Mental Retardation Act of 1966.

Defendant Class:

The defendant class are all directors of all mental health and mental retardation facilities in Pennsylvania, all of which are subject to the challenged statutes and all of which are subject to regulation by the defendant Secretary of Public Welfare.

For the purposes of this motion and the proposed classes, "facilities" refers to those institutions for residential care defined in Section 102 of the Mental Health and Mental Retardation Act of 1966 and in Section 105 of the Mental Health Procedures Act of 1976.

The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical (the plaintiffs number in the thousands, the defendants include scores of facility directors); there are questions of law and fact common to the class (see paragraph 13 of Amended and Supplemental Complaint); the claims of the representative parties are typical of the claims of the class (true as to both defendants and plaintiffs); the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

One important word with respect to the class representation and adequacy thereof. The Supreme Court's admonition to this Court that it "stop, look and listen" before certifying a class, noting the state's regulations and the potential distinction between younger and older children, *Kremens v. Bartley*, Slip Opinion at 14-15, should and must be responded to by emphasizing that this case deals with the *minimum* due process required for *all* com-

mitments, of whatever age the child, and whatever the alleged "disability." Thus, the facts of the case require no further counsel or further subclasses for a proper and adequate disposition. The Court might also wish to note that present counsel has properly and competently maintained this action as guardian *ad litem* and the Court might specifically make a finding of no conflict of interest among members of the plaintiff class.

There can be no doubt that a class action is an appropriate vehicle for determination of due process claims of mental patients. *E.g., Meisel v. Kremens,* 405 F. Supp. 1253 (E.D. Pa. 1975) (invalidating summary revocation of mental patients' long term leave); *Goldy v. Beal,* 429 F. Supp. 640 (M.D. Pa. 1976) (Three-Judge Court) (invalidating civil commitment statute); *Bell v. Wayne County General Hospital,* 384 F. Supp. 1085 (E.D. Mich. 1974) (civil commitment); *Lessard v. Schmidt,* 349 F. Supp. 1078 (E.D. Wis. 1972) (civil commitment); *Lynch v. Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974).

No further memorandum will be submitted in support of this motion, except at the Court's direction or in response to any filing by the defendants.

For the convenience of the Court, and should the Court not file a memorandum on this issue, plaintiffs have attached a draft proposed order for class action determination.

Respectfully submitted,

(s) David Ferleger

David Ferleger, Esquire
2321 Sansom Street
Philadelphia, Pa. 19103

Certificate of Service

David Ferleger, Esquire, hereby certifies that on the 8th day of November, 1977, he mailed true and correct copies of the foregoing to all counsel for the defendants herein and to counsel for the amici, by U.S. Mail, first class postage pre-paid.

(s) David Ferleger

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

INTERROGATORIES TO THE DEFENDANTS

Pursuant to Rule 33 of the Federal Rules of Civil Procedure, plaintiffs request the defendants to answer, under oath, the following interrogatories:

1. How many juveniles, mentally ill and mentally retarded, were confined in state owned and operated institutions for the mentally ill as of October 31, 1977, (1) under Section 201 of the Mental Health Procedures Act of 1976, (2) under 302, 303, 304 and 305 of that Act, (3) under Sections 402, 403, 405 and 406 of the Mental Health and Mental Retardation Act of 1966. For sections (1) and (2), "juvenile" means a person under 14; for section (3), juvenile means a person between 0 and 18.

2. How many juveniles (defined as a person between 0 and 18) were confined in state owned and operated state schools and hospitals for the retarded as of October 31, 1977, under Sections 402, 403, 405 and 406 of the Mental Health and Mental Retardation Act of 1966.

3. How many juveniles were confined as of October 31, 1977 in licensed facilities in Pennsylvania pursuant to the categories in interrogatory No. 1 and according to the definitions in that interrogatory.

4. For each juvenile identified in interrogatories 1 through 3 above, obtain the identity and nature of relationship of the applicant for admission/commitment, and specify in aggregate form that information (e.g., parent, foster parent, county welfare department, police, other relative, juvenile court official, neighbor).

Please reply within 30 days to David Ferleger, counsel for plaintiffs, at the address below.

(s) David Ferleger
David Ferleger, Esquire
2321 Sansom Street
Philadelphia, Pa. 19103
215-567-2828, 735-8409
Counsel for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

DEFENDANTS' ANSWER TO PLAINTIFFS' INTERROGATORIES

Pursuant to Rule 33 of the Federal Rules of Civil Procedure, Defendants here submit the following Answers to Plaintiffs' Interrogatories.

1. As of October 31, 1977, there were in state-owned and operated institutions for the mentally ill:

100 juveniles under Section 201;
0 juveniles under Section 302;
0 juveniles under Section 303;
8 juveniles under Section 304;
2 juveniles under Section 305;
0 juveniles under Section 402;
0 juveniles under Section 403;
0 juveniles under Section 405;
1 juvenile under Section 406.

2. As of October 31, 1977, there were in state-owned and operated centers for the retarded:

984 juveniles under Section 402;
1 juvenile under Section 403;
0 juveniles under Section 405;
66 juveniles under Section 406.

3. As of October 31, 1977, there were in licensed facilities in Pennsylvania:

juveniles under Section 201;
juveniles under Section 302;
juveniles under Section 303;
juveniles under Section 304;
juveniles under Section 305;
2052 juveniles under Section 402;
3 juveniles under Section 403;
0 juveniles under Section 405;
47 juveniles under Section 406.

4. The juveniles identified in paragraph one through three above were admitted/committed to these institutions by persons or agencies as follows:

2689 by natural parent;
5 by foster parent;
300 by county welfare agencies;
0 by police;
21 by other relatives;
119 by Juvenile Court;
0 by neighbor;
10 by guardian;
120 by others.

Respectfully submitted,
(s) Norman J. Watkins
NORMAN J. WATKINS
Deputy Attorney General
ROBERT B. HOFFMAN
Assistant Attorney General
J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation
ROBERT P. KANE
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

I, MARGARET UNDERKOFFLER, being duly sworn according to law, hereby depose and say that:

1. The foregoing answer on behalf of Defendants to Plaintiffs' Interrogatories are true and correct to the best of my knowledge, information and belief.

(s) Margaret Underkoffler
Margaret Underkoffler

Subscribed and sworn to before me this 8th day of December, 1977.

Eva R. Hartman
Notary
Notary Public

My Commission Expires May 13, 1978.
(Seal)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

I, KATHLEEN M. ETZWEILER, being duly sworn according to law, hereby depose and say that:

1. The foregoing answers on behalf of Defendants to Plaintiffs' Interrogatories are true and correct to the best of my knowledge, information and belief.

(s) Kathleen M. Etzweiler
Kathleen M. Etzweiler

Subscribed and sworn to before me this 8th day of December, 1977.

Eva R. Hartman
Notary
Notary Public

My Commission Expires May 13, 1978.
(Seal)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

DEFENDANTS' SUPPLEMENTAL ANSWERS TO PLAINTIFFS' INTERROGATORIES

Pursuant to Rule 33 of the Federal Rules of Civil Procedure, Defendants here submit the following Supplemental Answers to Plaintiffs' Interrogatories. The Supplemental Answers provide information on the number of juveniles in licensed mental health facilities and the manner of their placement, in response to questions three (3) and four (4) of Plaintiffs' Interrogatories.

3. As of October 31, 1977, there were in licensed facilities in Pennsylvania:

250 juveniles under Section 201
0 juveniles under Section 302
0 juveniles under Section 303
0 juveniles under Section 304
0 juveniles under Section 305

4. The juveniles identified in paragraph three (3) above were admitted/committed to these institutions by persons or agencies as follows:

249 by natural parent
0 by foster parent

1 by county welfare agency
0 by police
0 by other relatives
0 by Juvenile Court
0 by neighbor
0 by guardian
0 by others

Respectfully submitted,
(s) Norman J. Watkins
Norman J. Watkins
Deputy Attorney General
Robert B. Hoffman
Assistant Attorney General
J. Justin Blewitt, Jr.
Chief, Civil Litigation
Robert P. Kane
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

I, Margaret Underkoffler, being duly sworn according to law, hereby depose and say that:

1. The foregoing answers on behalf of Defendants to Plaintiffs' Interrogatories are true and correct to the best of my knowledge, information, and belief.

(s) Margaret Underkoffler
Margaret Underkoffler

Subscribed and Sworn to before me this 19th day of December, 1977.

Eva R. Hartman
Notary
Notary Public

My Commission Expires May 13, 1978.
(Seal)

Certificate of Service

AND NOW, this 22nd day of December, 1977, I, Norman J. Watkins, Deputy Attorney General for the Commonwealth of Pennsylvania, counsel for Defendants, hereby certify that on Thursday, December 22, 1977, I served Defendants' Supplemental Answers to Plaintiffs' Interrogatories by depositing said document in the United States Mail, postage prepaid, addressed to:

David Ferleger, Esquire
2321 Sansom Street
Philadelphia, PA 19103

(s) Norman J. Watkins
NORMAN J. WATKINS
Deputy Attorney General

Patients in Public Institutions as of October 31, 1977

	Mental Health Procedures Act of 1976												MH/MR Act of 1966									
	Sections												Sections									
	Ages 0 - 14						Ages 15 - 18						Ages 0 - 14					Ages 15 - 18				
	TOTAL	201	302	303	304	305	TOTAL	201	302	303	304	305	TOTAL	402	403	405	406	TOTAL	402	403	405	406
PPI	11	11																				
mbreeville	0													5					3			1
orristown	0																					
stern State School	40	20			8	2																
ve-ford	10	10																				
iladelphia	0																					
nnhurst																						
odhaven														8			9		18			17
llentown	27	27												49			1		61			5
arks Summit	0																					
rview	0																					
treat	0																					
rnersville	0																					
nburg																						
te Haven														16			3		74			6
ville	0													59			3		51			5
rrisburg	0																					
lidaysburg	0																					
erset	0																					
oona Center																						
sson														30					34			
nsburg														10					34			
relton														24					158			
insgrove														19			1		30			2
mont														10					42			1
view																						
rance	21	21																				
ren	0																					
dville	0																					
ch	1	1																				
k														0	0	0	0		0	0	0	0
tern														52			3		23			1
														29	1		6		85			2

BEST COPY AVAILABLE

Procedures Act of 1976
MH/MR Act of 1966

Juveniles in Public Institutions as of October 31, 1977

Institutionalized Juveniles Admitted/Commited by:

	TOTAL		Parent		Foster Parent		Co. Welfare Dept.		Police		Other Relative		Juvenile Court Official		Neighbor		Guardian		Other (specify)	
	76	66*	76	66	76	66	76	66	76	66	76	66	76	66	76	66	76	66	76	66
EPPI			5				6													
Embreeville				3				5						1						
Norristown																				
Eastern State School			27				2						11							
Haverford			9														1			
Philadelphia														36						
Pennhurst				27				4												
Woodhaven				77				12						6				1		
Allentown			27					1												
Clarks Summit																				
Farview																				
Retreat																				
Wernersville																				
Hamburg				37				2						9				1		
White Haven				78				1?				1								
Danville																				
Harrisburg																				
Hollidaysburg																				
Somerset																				
Altoona Center				59		1		4												
Cresson				41				2				1								
Ebensburg				170				8						2				1		1
Laurelton				44				1				2								5
Selinsgrove				37																16
Dixmont												5	-							
Mayview			16										3							
Torrance																				
Warren																				
Woodville			1																	
March																				
Polk				135										4						
Western			1	109				4				2		8				1		

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

DEFENDANTS' RESPONSE TO PLAINTIFFS' MOTION FOR CLASS ACTION

Defendants hereby respond and object to Plaintiffs' Motion for Class Certification as follows:

1. The factual and legal considerations for children who have been institutionalized at the behest of a public service agency differ significantly from those who are institutionalized by his or her parent(s). Accordingly, it is inappropriate for one group to represent the interests of the other, as has been proposed by the plaintiffs.

2. The case is inappropriate for certification of a defendant class in that the legal and factual considerations with respect to directors of state-owned and operated facilities differ significantly from those involved with respect to directors of private licensed facilities.

3. The proposed defendants are not so numerous as to make joinder impractical as required by F.R.C.P. 23.

WHEREFORE, defendants respectfully request that the plaintiff class be certified only in accordance with Paragraph 1 above. Further, defendants request that the

Court refuse to certify a defendant class for the reasons set forth in Paragraphs 2 and 3 above.

Respectfully submitted,

NORMAN J. WATKINS
Deputy Attorney General
ROBERT P. HOFFMAN
Assistant Attorney General
J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation
ROBERT P. KANE
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

STIPULATION OF COUNSEL

I. *Stipulation of Facts*

The following facts are stipulated to by and between the plaintiffs and the defendants through their counsel, subject to the objections noted at paragraphs 47 and 48 below:

1. In this action, plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief for violations of their civil rights resulting from the operation of Pennsylvania statutes which permit their indeterminate confinement in institutions for the mentally ill and mentally retarded under color of state law with no right to notice, hearing, counsel and other procedural safeguards. The statutes are challenged on the ground that they conflict with the plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment of the United States Constitution.

2. The defendants are those state officials who accept and receive into custody the named plaintiffs, minors, upon the application of parents or guardians such as welfare departments and child care agencies.

3. This case has been before the Court as *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), vacated and remanded, 96 S.Ct. 1709 (1977). This amended and supplemental complaint substitutes new class representatives and informs the Court of recent state statutory developments.

4. Jurisdiction is asserted under 28 U.S.C. 1331 which provides for original federal question jurisdiction. The amount [claimed] in controversy, exclusive of interests and costs, exceeds $10,000.

5. Jurisdiction is also asserted under 28 U.S.C. 1343(3) which provides for original jurisdiction in all suits authorized by 42 U.S.C. 1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States and by federal law.

6. The federal statutes and rules under which plaintiffs' claim relief are 28 U.S.C. 2201, 2202, 2281, 2284, Rules 57 and 65 of the Federal Rules of Civil Procedure (all of which relate to declaratory judgments, injunctions and three-judge courts) and 42 U.S.C. 1983 and 1988 (which relate to civil rights actions).

7. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. 2281 and 2284 since the plaintiffs seek an injunction to restrain defendants, state officials, from the enforcement, execution and operation of portions of state statutes of state-wide applicability on the ground that said statutes are contrary to the United States Constitution. This action was filed prior to the enactment of Public Law 94-381 which amended the three-judge court statutes.

8. The named plaintiffs bring this action in their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

9. The questions of law and fact involved are:

a. Are the representative plaintiff parties, and their class members admitted/committed to mental institutions pursuant to the challenged statutes and without notice, counsel, hearing and other procedural safeguards?

b. Do the defendants operate, execute and enforce the challenged statutes?

c. Are the challenged statutes contrary to the Due Process Clause of the Fourteenth Amendment to the United States Constitution?

10. The named plaintiffs sue by their next friend and guardian ad litem, appointed by the Court pursuant to Rule 17 of the Federal Rules of Civil Procedure.

11. The parties agree that the named plaintiffs may be designated by their actual given names and the initial of their surnames. Their full identities have been made known to the defendants.

12. The first group of plaintiffs, those confined at Haverford State Hospital, under the Mental Health Procedures Act of 1976, are all the juveniles under 14 years of age admitted/committed under Section 201 as of October 31, 1977, to that institution.

13. The second group of plaintiffs are persons with mental retardation confined under the Mental Health and Mental Retardation Act of 1966, Sections 402 and

403, in two institutions, one near Philadelphia in the eastern part of Pennsylvania and one near Pittsburgh in the west.

First Group of Plaintiffs; Those at Haverford State Hospital

14. Plaintiff Kevin S., born May 2, 1965, is a citizen of Pennsylvania. He is 12 years old.

15. Plaintiff Richard S. is now 13 years old and a citizen of Pennsylvania. He was born September 24, 1964.

16. Plaintiff James Paul M. is 7 years old, having been born on November 10, 1969. He is a citizen of Pennsylvania.

17. Plaintiff Raymond C. was born on September 9, 1964, is a citizen of Pennsylvania, and is 13 years old.

18. Plaintiff William B. was born June 18, 1968, is 9 years old and is a citizen of Pennsylvania.

19. Plaintiff Eddie B. was born October 26, 1965, is a citizen of Pennsylvania, and is 12 years old.

20. Plaintiff Francis B. was born January 9, 1967, is 10 years old and a citizen of Pennsylvania.

21. Maria L., plaintiff in this action, was born August 26, 1965, is 12 years old and a citizen of Pennsylvania.

22. Thomas W., born February 14, 1966, is 11 years old and a citizen of Pennsylvania.

Second Group of Plaintiffs; Those at Polk and Pennhurst State School and Hospitals

23. Plaintiff Nancy Louise D., born December 10, 1960, is a 16 year old citizen of Pennsylvania.

24. Plaintiff Gina S. was born on July 30, 1961, and is a citizen of Pennsylvania. She is 16 years of age.

25. Plaintiff George S. was born February 10, 1963, is 14 years old, and is a citizen of Pennsylvania.

Defendants

26. Defendant Secretary of Public Welfare is the Pennsylvania state official who, in that capacity, has the power and duty to enforce the challenged statutes and all regulations necessary and appropriate to the proper accomplishment of those provisions and "to operate and assign functions to all State facilities." See Sections 201 (2) and 202 (a) of the Mental Health and Mental Retardation Act of 1966, and Section 105 of the Mental Health Procedures Act of 1976 ("Treatment Facilities"), and 6 Pa. Bull. 2115 at Section 7100.1.2 (definition of "approved facility"). Aldo Colautti currently occupies that office; Frank Beal, who was Secretary at the time this action was filed, left office on February 15, 1978.

27. Defendant John Fong is the director of Haverford State Hospital and is charged with supervision and administration of the facility. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. 4102, 4203 and 4417. It is to Fong or his delegate that applications for admission, commitment or release of the plaintiffs must be made. Under Section 202 of the 1976 Act, application for examination and treatment may also be made to the county mental health/mental retardation administrator who designates an approved facility for examination and for such treatment as may be appropriate. Haverford State Hospital is an approved facility under Section 105 of the Mental Health Procedures Act of 1976.

28. Defendants Nicholas D'Aluisio and C. Duane Youngberg are, respectively, directors of the Polk State School and Hospital and the Pennhurst State School and Hospital, both institutions for persons with mental retardation. They are charged with supervision and administration of those facilities. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. 4102, 4203 and 4417. It is to D'Aluisio, Youngberg or their delegates that applications for admission, commitment or release of the plaintiffs must be made. See sections 402(b), 403(b) and 403(c) of the Mental Health and Mental Retardation Act of 1966.

Haverford State Hospital

29. Haverford State Hospital is an institution for the mentally ill located in a rural/suburban area outside Philadelphia.

30. The institution's score of buildings cover a large hilly area in one corner of which is Building 14, a building with two large wards. The west ward houses geriatric patients; the door to it is generally unlocked. The east ward houses juveniles.

31. As of October 31, 1977, there were a total of 12 juveniles in the Children's Unit in Building 14. Three were committed by juvenile courts, after hearings; 9 were admitted/committed under the challenged statutes, upon application to the institution by parents or guardians.

32. Entry into the Children's Unit in Building 14 is through a door that is kept locked. When a buzzer is rung, a worker inside comes to unlock the door. The door bears a sign which reads, "VISITING HOURS—1:30-4:30 Weekends and Holidays. No evening visits. (signed) Dr. Bernard Kanter."

33. The Unit consists of two hallways which cross at a glass-walled nursing station. One hallway continues from the entrance door to a large dormitory area for male patients. Along that hallway are two carpeted unfurnished rooms used for "seclusion" or "time-out" purposes. The second hall has a large dayroom at one end and, at the other end, a large dormitory area for female patients.

34. (Modified orally) In the nursing station is a bank of television monitors which are used to surveil the patients in all areas of the Unit, including the halls and dormitories.

35. Adjacent to the building are playing areas fenced in by chain link fences about 12 feet high.

36. Dr. Carl Hammer is a part-time psychiatrist in a unit other than the Children's Unit at Haverford State Hospital.

37. All mental health and mental retardation facilities in Pennsylvania which are not state-owned and operated must be licensed and/or approved by the Department of Public Welfare. As part of the approval/licensing, such facilities have been required and are required to utilize and act in conformity with the commitment and admission procedures in both the 1966 Act and the 1976 Act.

38. Since the effective date of the 1976 Act, the regulations adopted by the Department of Public Welfare in 1973 (reproduced at 786a, footnote 5 of the July 24, 1975 Opinion of the District Court) are used by the defendants and apply only to juveniles admitted/committed as mentally retarded under Sections 402 and 403 of the 1966 Act. The regulations do not apply to juveniles ad-

mitted/committed as mentally ill under Section 201 of the 1976 Act.

39. Except as may be provided in the 1973 regulations referred to above, when institutionalized juveniles object to their confinement or express a desire to leave the institution, as the named plaintiffs have through their guardian ad litem and as some have done personally, the defendants do not provide counsel or take action to assure either discharge or a hearing on the juvenile's objections because the defendants believe, as a matter of law, that they are not required to do so.

II. EVIDENCE

40. The evidence which was admitted in the initial proceeding, including all testimony, depositions, exhibits, interrogatories, objections and rulings shall be deemed included in the record in these proceedings. Further, for the convenience of the parties and the Court, the printed Appendix, which was used in the Supreme Court, No. 75-1064, with permission of this Court shall be used in these proceedings.

41. As used in this stipulation, the following terms have the following meanings and references:

a. "Juveniles" mean persons 18 years of age or younger admitted/committed under Sections 402-3 and 405-6 of the Mental Health and Mental Retardation Act of 1966, and those persons under 14 years of age admitted/committed under Sections 201, 302-5 of the Mental Health Procedures Act of 1976.

b. "Mental Health and Mental Retardation Act of 1966", "MH/MR Act of 1966", "1966 Act" and "66" refer to 50 P.S. §4101 et seq.

c. "Mental Health Procedures Act of 1976", "MHP Act of 1976", "1976 Act" and "76" refer to 50 P.S. §7101 et seq.

d. Sections 201, 302, 303, 304 and 305 refer to the corresponding sections of the 1976 Act.

e. Sections 402, 403, 405 and 406 refer to the corresponding sections of the 1966 Act.

f. "Licensed mental health facilities" refers to those residential mental institutions not operated by the State and which are licensed or approved by the Department of Public Welfare to provide mental health and retardation services. See Section 102, 201, 202(a), 203 and 417 of the 1966 Act; Section 105 of the 1976 Act (this section applies as well to state operated mental institutions); 6 Pa. Bull. 2115 at Section 7100.1.2 (definition of "approved facility").

42. The Defendants' Answer to Plaintiffs' Interrogatories attached as Exhibit A hereto, and the Defendants' Supplemental Answers to Plaintiffs' Interrogatories, attached as Exhibit B hereto, indicate the number of persons in Pennsylvania admitted/committed under the challenged statutes and the applicants for their admission/commitment as of October 31, 1977. The information referred to in paragraphs 42, 43, and 44 is substantially accurate at this date.

43. Exhibit C is a table indicating, for all juveniles in state-owned and operated institutions, the age ranges and statutory provisions under which they were admitted/committed, by institution.

44. Exhibit D is a table indicating all juveniles in state-owned and operated institutions, by institution, and indicating the identity and nature of relationship of the

applicant for admission/commitment by various specified categories.

45. Of the 119 juveniles listed in Exhibit A, paragraph 4, as having been admitted/committed by "Juvenile Court", 114 were committed by the Court under Section 406 and 5 were admitted/committed by the Court under Section 201.

46. Defendants have not been precluded from offering any additional evidence over and above that which has been offered and admitted or excluded by a specific order of this court. The same is true of plaintiffs. [Further offers of proof may be made at the hearing of this matter.]

III. OBJECTIONS

47. Defendants object to the admission of the facts stipulated at paragraphs 29, 30, 32, and 36 above on grounds of relevance and on the basis that they [fail to provide a complete or accurate depiction of Haverford State Hospital.]

48. Plaintiffs object to the admission of Part A of the Exhibits 1 through 12, described below, on two grounds: first, their relevance because they are preadmission material, and second, that [some portions] of this material [were] not received by the institution until some time after the admission/commitment process was concluded.

IV. RECORDS OF NAMED PLAINTIFFS

49. Exhibits 1 through 12 which are to be submitted into evidence are portions of the official records of the named plaintiffs at their respective institutions, referred to as "the Records Exhibits".

50. Each of the "Records Exhibits" includes a Part A and a Part B.

51. Part A is pre-admission material including such things as background referral material, school and outpatient records. It is specifically noted by the parties that there is no stipulation that all of the material in Part A was received by the institution prior to the completion of the admission process.

52. Part B on Haverford State Hospital patients consists of the institution's Admission Note.

Psychosocial history, psychological evaluation and a New Case Conference note, all developed shortly after admission/commitment. Part B also includes the statutory admission/commitment forms. For plaintiffs at Polk and Pennhurst, Part B consists of the reports of various examinations conducted shortly after admission. Part B also includes the statutory admission/commitment forms.

53. The parties will finalize and present to the Court at the March 31, 1978 hearing the contents of Exhibits 1 through 12.

NORMAN J. WATKINS,
ESQUIRE
ROBERT B. HOFFMAN,
ESQUIRE
Department of Justice
Capitol Annex
Harrisburg, PA 17120
Attorneys for Defendants
DAVID FERLEGER, ESQUIRE
2321 Sansom Street
Philadelphia, PA 19103
Attorney for Plaintiffs

Exhibit C

Juveniles in Public Institutions as of October 31, 1977

	Mental Health Procedures Act of 1976												MH/MR Act of 1966									
	Sections												Sections									
	Ages 0 - 14						Ages 15 - 18						Ages 0 - 14					Ages 15 - 18				
	TOTAL	201	302	303	304	305	TOTAL	201	302	303	304	305	TOTAL	402	403	405	406	TOTAL	402	403	405	406
EPPI	11	11																				
Embreeville	0													5					3			1
Norristown	0																					
Eastern State School	40	30			8	2																
Haverford	10	10																				
Philadelphia	0																					
Pennhurst														8			9		18			17
Woodhaven														49			1		61			5
Allentown	27	27																				
Clarks Summit	0																					
Farview	0																					
Retreat	0																					
Wernersville	0																					
Hamburg														16			3		74			6
White Haven														59			3		51			5
Danville	0																					
Harrisburg	0																					
Hollidaysburg	0																					
Somerset	0																					
Altoona Center														30					34			
Cresson														10					34			
Ebensburg														24					158			
Laurelton														19			1		30			2
Selinsgrove														10					42			1
Dixmont																						
Mayview	21	21																				
Torrance	0																					
Warren	0																					
Woodville	1	1																				
March														0	0	0	0		0	0	0	0
Polk														52			3		83			1
Western														29	1		6		85			2

Exhibit D

954½a

Procedures Act of 1976
MH/MR Act of 1966

Juveniles in Public Institutions as of October 31, 1977

Institutionalized Juveniles Admitted/Commited by:

	TOTAL		Parent		Foster Parent		Co. Welfare Dept.		Police		Other Relative		Juvenile Court Official		Neighbor		Guardian		Other (specify)	
	76	66*	76	66	76	66	76	66	76	66	76	66	76	66	76	66	76	66	76	66
EPPI			5				6													
Embreeville				3				5						1						
Norristown																				
Eastern State School			27				2						11							
Haverford			9														1			
Philadelphia														26						
Pennhurst				27				4												
Woodhaven				97				12						6				1		
Allentown			27					1												
Clarks Summit																				
Farview																				
Retreat																				
Wernersville																				
Hamburg				37				2						9				1		
White Haven				98				19				1								
Danville																				
Harrisburg																				
Hollidaysburg																				
Somerset																				
Altoona Center				59		1		4												
Cresson				41				2				1								
Ebensburg				170				8						2				1		1
Laurelton				44				1				2								5
Selinsgrove				37																16
Dixmont												5								
Mayview			16										3							
Torrance																				
Warren																				
Woodville			1																	
March																				
Polk				135										4						
Western			1	108				4				2		8				1		

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

ORDER

The parties to the above-captioned matter have requested that we rule on two preliminary evidentiary matters in order to facilitate the process of stipulating to facts prior to the hearing. NOW, March 10, 1978, upon consideration of the memoranda of law submitted by the parties, IT IS ORDERED:

1. The findings of fact and conclusions of law contained in *Halderman v. Pennhurst State School and Hospital,* Civil Action No. 74-1345 (E.D. Pa., Dec. 23, 1977), are inadmissible on grounds of relevance. However, evidence generally relating to the deprivation of liberty inherent in confinement in institutions and exposure to institutional environment is admissible.

2. Portions of the plaintiffs' medical records relating to the process of admission to the institutions are relevant and admissible. The remaining portions of the medical records are not relevant to this action and are therefore not admissible.

Judge John J. Gibbons and Judge Raymond J. Broderick have advised me by telephone that they agree with the contents of this Order.

Daniel H. Huyett,
J.
3/13/78

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

MEMORANDUM AND ORDER CERTIFYING DEFENDANT CLASS

HUYETT, J., March 28, 1978:

Plaintiff has moved for certification of both plaintiff and defendant classes pursuant to F.R.C.P. 23. The proposed defendant class is defined as "directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare." Representatives of the class are the Secretary of Public Welfare and directors of three state-owned and operated facilities. Plaintiffs propose that this class be certified pursuant to F.R.C.P. 23(a) and 23(b)(1)(B) or 23(b)(2).

Although we are, at this point, reserving our decision on certification of a plaintiff class, we see no reason to delay certification of a defendant class. For the reasons stated below, we certify the defendant class as defined by plaintiff.

Two of the requirements of Rule 23(a), numerosity and the existence of common questions of law and fact, clearly are met. With respect to numerosity, there are 30 state-owned and operated institutions in Pennsylvania and more than 400 state-licensed facilities. The question of law common to all of these defendants is the validity of the challenged state statutes and regulations governing voluntary commitment of mentally ill and mentally retarded juveniles.

The most important area of inquiry when considering the propriety of a defendant class is to assure that the class representatives will adequately represent the interests of the absent class members. This is assured by requiring that the interests of the class representative be typical of those of absent class members, that the class be conflict-free, and that the class representative have a personal interest in the issues so that the defense mounted will be vigorous. *Note, Defendant Class Actions,* 91 Harv. L. Rev. 630, 639-40 (1978).

Those requirements are met here. The Secretary of Public Welfare, the named class defendant, has a strong interest in defending the validity of the challenged statutes and regulations. In *Commonwealth v. Rizzo,* 530 F. 2d 501 (3d Cir. 1976), the Third Circuit, in discussing the adequacy of representation problem in the context of a motion to intervene as of right, stated:

> [A] presumption of adequate representation arises when the representative is a governmental body or officer charged by law with representing the interests of the absentee. . . . Where official policies and practices are challenged, it seems unlikely that anyone could be better situated to defend than the governmental department involved and its officers.

Id. at 505. *See Pennsylvania Ass'n. for Retarded Children v. Pennsylvania,* 343 F. Supp. 279 (E.D. Pa. 1972).

The same could be said here. The Secretary of Public Welfare is charged with enforcing the statutes and regulations being challenged by the instant lawsuit. Furthermore, we see no possible conflict within the class, since the challenged statutes and regulations are applicable to all of Pennsylvania's mental health institutions, whether state-owned and operated, or privately owned. Thus, we conclude that the Secretary of Public Welfare is an adequate representative of the class.

In conclusion, we certify pursuant to F.R.C.P. 23(a), and 23(b)(2)[1] the following class:

> The directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare.

Since this is a 23(b)(2) class, no notice need be given to absent class members.

Honorable John J. Gibbons and Honorable Raymond J. Broderick advise me that they are in accord with this Memorandum and Order and authorize me to issue the Memorandum and Order on behalf of the three judge court.

Daniel H. Huyett,
J.

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[1] The defendant class also qualifies for certification pursuant to F.R.C.P. 23(b)(1)(B). In view of the binding effect of the statute and the Department of Public Welfare's regulations on all mental health and retardation facilities, "adjudication with respect to individual members of the class . . . would as a practical matter be dispositive of the interests of the other members not parties to the adjudications."

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

ORDER

NOW, March 28, 1978, upon consideration of plaintiffs' motion for certification of a defendant class, and for the reasons stated in the accompanying memorandum, IT IS ORDERED that the plaintiffs' motion is GRANTED. The defendant class is defined as

> The directors of all mental health and retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare.

Daniel H. Huyett,
J.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

OFFER OF PROOF AND REQUEST FOR EVIDENTIARY RULING

In its opinion remanding this case, the Supreme Court noted that this Court could consider in any further proceedings possible differing considerations which exist between the young and very young and between those persons alleged to be mentally ill and retarded. 431 U.S. 119, 135.

Plaintiffs hereby offer to present expert testimony and factual testimony to the effect that—for the purposes of the minimum due process safeguards declared by the Court in its 1975 Opinion and sought by the plaintiffs now—there are no relevant differences between the mentally ill and the retarded or among juveniles of all ages.

Plaintiffs believe that such evidence (to the extent to which it would not be redundant) is unnecessary and irrelevant and that, as a matter of constitutional law, the minimum due process procedures are the same for all plaintiffs, although, of course, some subgroups might be entitled to a greater amount not at issue in this case.

However, should the Court wish to hear such evidence and find it relevant, plaintiffs will prepare and present it in whatever manner the Court directs.

(s) David Ferleger
David Ferleger, Esquire
Attorney and Guardian Ad Litem for Plaintiffs

CERTIFICATE OF SERVICE

David Ferleger, Esquire, hereby certifies that on the 31st day of March, 1978, he served a true and correct copy of the foregoing Offer of Proof and Request for Evidentiary Ruling upon the counsel for defendants, Norman J. Watkins, in open court.

David Ferleger

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

DEFENDANTS' SUPPLEMENTAL MEMORANDUM

I. *Introduction*

On March 31, 1978, the final hearing was held in this matter. However, several points arose on which the court requested additional briefing.[1] Specifically, the defendants were requested to address the relevance of Part A[2] of the individual plaintiffs' hospital records and the question of what type of hearing should be ordered if one is required.

II. *Relevance of Part A of the Individual Plaintiffs' Hospital Records*

Professor Moore has noted that the test of relevance ". . . depends mainly upon logic . . ." 10 Moore's Federal Practice ¶400.01, at IV-2 (3rd Ed. 1976). Thus the

[1] Both plaintiffs and defendants filed comprehensive pre-trial briefs covering all of the major issues.

[2] These hospital records were separated into Parts "A", "B", and "C". Part "A" concerns all pre-admission material. Part "B" covers records from and including the actual admission note through the first staff conference regarding the patient. Part "B" has been accepted into evidence without objection. Finally, Part "C" of these contained all of the treatment records—however, these were excluded by the court (Order, 3-13-78).

vagueries of the definition of relevance provided in the rules[3] must be resolved logically. While the admissibility provisions of Rule 43(a) have now been superseded by the Federal Rules of Evidence, cases decided under Rule 43 are still instructive for the concept of relevance has not changed significantly. 10 Moore's Federal Practice §400.01 at IV-4 (3rd Ed. 1976). And these cases counsel that the contested records are indeed relevant and therefore admissible.[4]

Initially, it should be noted that the decisions are uniform in favoring admissibility over exclusion on relevance grounds. *Caton v. Hardamon,* 496 F.2d 6 (7th Cir. 1974); *Hasson v. Stafford,* 472 F.2d 88 (3rd Cir. 1973); *Courtland v. Walston & Co.,* 340 F. Supp. 1076 (S.D. N.Y. 1972). Thus, if there is doubt regarding the relevance of a particular piece of evidence, it should be admitted. *United States v. Lykes Bros. Steamship Co.,* 432 F.2d 1076 (5th Cir. 1970); 10 Moore's Federal Practice §400.12[2] at IV-18 (3rd Ed. 1976).

Defendants offered the entire file for each plaintiff for several reasons. The first and foremost of these was to insure that the court has the whole picture. The fact that plaintiffs have repeatedly excerpted portions of these records in their complaint[5] highlights their relevance to

[3] Rule 401 provides:

"Relevant evidence" means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. Fed. R. Evid. 401.

[4] Plaintiffs' sole objection to these records is on grounds of relevance.

[5] See e.g. Paragraphs 39-40, 42, 44, 51-54, 66-67, and 73-74 of the complaint.

this action. Plaintiffs have used portions of these very records to prove their claim—surely the defendants may use the remainder as defense.

Under the rules it is clear that background material such as this should be admitted. Thus, even if the excerpts from the records were not in controversy—further background material tending to clarify the issue is certainly relevant to the action. 10 Moore's Federal Practice §401.06[2] at IV-§1 (3rd Ed. 1976). In fact, this Court's Order dated March 13, 1978, explicitly recognizes the relevance of evidence concerning the admission process, which of course, is the sum and substance of this material. This material is necessary to accurately show what the admission process was for each of the plaintiffs. Inasmuch as it is this very process which the plaintiffs claim violates the Constitution, the relevance of these records is clear beyond peradventure. These records, substantially all of which were possessed by the defendants prior to the actual admission,[6] demonstrate the care and scrutiny given to each case prior to admission.

Finally, the attached affidavits emphatically underscore the relevance of these records. Substantially, all of these materials were in the hands of the admitting facility's staff prior to admission, and those few that weren't related to evaluations and the like that preceded the admission. These records, to a great extent, reflect the professional bases of the recommendation for inpatient care—which recommendation the plaintiffs so vigorously attack. Thus, on the basis of the foregoing, it is strongly urged that these records are relevant to this matter, and should be admitted as evidence.

[6] See affidavits of Ellen N. Lynch, Marcia Murtagh and Mary Thompson, which are attached, regarding the plaintiffs at Haverford State Hospital. Regarding the three mentally retarded plaintiffs—Nancy Louise D., Gina S. and George S.—cover letters in the records reflect that all of that material was received prior to admission.

II. TYPE OF HEARING

At the outset defendants reassert their position that nothing in addition to that which is presently provided by state law in the way of due process in the admission process for children is mandated by the Fourteenth Amendment. Nevertheless, and on the assumption that this Court finds the present scheme wanting in that regard, defendants recommend the following elements be considered:

(a) any hearing procedure should be nonjudicial, taking place before one or more professionals in the field.

(b) Counsel should not be mandatory.

(c) the hearing should be informal, and not of record.

(d) the normal administrative appellate process should be utilized. 71 Pa. Stat. Ann. 1710.41.

(e) the hearing should not be required to be pre-admission, but rather within a reasonable time thereafter.

As the foregoing makes clear, the defendants strongly urge that imposition of a rigid adversary juidicial pre-commitment hearing would indeed be counter-productive. To the extent the due process clause may apply in the admission of a child to a mental health facility—the process

due should be administrative and informal. See *Board of Curators v. Horowitz,* U.S. , 46 U.S.L.W. 4179 (March 1, 1978).

(s) Norman J. Watkins
NORMAN J. WATKINS
Deputy Attorney General
J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation
ROBERT P. KANE
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

MARY THOMPSON, being duly sworn in accordance with law, does state and affirm as follows:

1. I am a Psychological Associate III and work part-time as a staff psychologist in the Children's Unit, Haverford State Hospital. I have worked at Haverford State for approximately 11 years and have worked in the Children's Unit since December 1976.

2. In that capacity, I provide psychological services to patients and review prior to admission psychological

examinations submitted by the referring agency to insure their accuracy and timeliness.

3. Part A of the records of Raymond C. (Defendants' Exhibit 5) includes a two page psychological report prepared by Anthony J. Mannino, District Psychologist on March 8, 1977.

4. Attached to that report is a note handwritten by me stating "Attached Psychological from Leedum School (3/77) will serve as psychological requirement for this hospitalization."

5. My note is undated and I am uncertain of the precise date on which it was written or on which the psychological report was received.

6. Based upon policies and procedures in the Children's Unit, which requires a report of a psychological examination to be submitted prior to a voluntary admission, I am certain that the report was received and my note written prior to admission.

7. The information set forth above is true and correct to the best of my knowledge, information and belief.

(s) Mary W. Thompson
Mary Thompson

Subscribed and sworn to before me this 11th day of April, 1978.

Mary C. Jarrell
Notary
[Notary Stamp Illegible]

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

MARCIA MURTAGH, M.S.S., being duly sworn in accordance with law, does state and affirm as follows:

1. I am the Chief Social Worker in the Children's Unit at Haverford State Hospital and have served in that capacity since May 9, 1977.

2. Prior to that, I was a Social Worker at Embreeville State Hospital.

3. In my present capacity, I serve as a member of the treatment team for patients in the Children's Unit and am involved in the admission process for many of them.

4. I am familiar with all of the nine (9) plaintiffs who were, as of October 31, 1977, patients in the Unit.

5. I was directly involved in the admission of Raymond C., James Paul M., Kevin S., and Richard S., Defendants' Exhibits 6, 7, and 8 respectively.

6. I have reviewed the material contained in Part A of the records presented to the Court regarding these three patients to determine which particular records were received by the Children's Unit prior to the child's admission. In doing this, I have reviewed correspondence from referring agencies not presently included in Part A

and my own independent recollection of the admission processes of these three children. Based upon them, I am able to state with certainty, as described individually below, which records were received prior to admission.

James Paul M. (Defendants' Exhibit 6)

7. James Paul M. was seen in a pre-admission interview on October 14, 1977 and admitted October 17, 1977.

8. All material included in Part A of his records was sent to me by letter of August 30, 1977 from Mr. Francis Baird, Life Guidances Services (Base Service Unit II). A copy of that letter, not presently in Part A, is attached hereto as Exhibit A.

Kevin S. (Defendants' Exhibit 7)

9. Kevin S. was seen in a pre-admission interview on July 13, 1977 and was admitted July 18, 1977.

10. Psychological and Psychiatric Evaluations in Part A were received by Mrs. Ellen Lynch, by letter of June 30, 1977, from Mrs. Virginia C. Long, Director of Special Education, William Penn School District. This letter is presently included in Part A.

11. All other material in Part A including records from Delaware County Child Care and Base Service Unit II were received prior to pre-admission, according to the pre-admission note prepared by me on July 13, 1977, although I am uncertain of the precise date.

Richard S. (Defendants' Exhibit 8)

12. Richard S. was seen in a pre-admission interview on June 1, 1977 and admitted June 6, 1977.

13. Certain materials in Part A pre-dating January 12, 1977, were received by Mrs. Lynch, attached to a letter of that date from Luana C. Goodwin, Child Care Services. See Affidavit of Ellen Lynch.

14. Additional material in Part A, prepared by Silver Springs-Martin Luther School subsequent to January 12, 1977, were also received prior to the pre-admission interview of June 1, 1977.

15. Although I am uncertain of the precise date on which this material was received, I recall having seen and reviewed this material shortly after I began work in the Children's Unit on May 9, 1977.

16. The only document in Part A which was not received prior to admission is a one page, handwritten School Report dated June 15, 1977.

Raymond C. (Defendants' Exhibit 5)

17. Raymond C. was seen in a pre-admission interview on September 28, 1977.

18. In addition to those records in Part A received by Mrs. Lynch prior to admission, records from Delaware County Court, Juvenile Division were sent to me attached to a letter of September 14, 1977, from Janet Smith, Intake Officer. A copy of that letter, not presently included in Part A, is attached hereto as Exhibit B.

Tom W. (Defendants' Exhibit 12)

19. I was not involved in the actual admission of Tom W., which occurred on June 2, 1977.

20. On June 6, 1977, however, I received from Mr. Lutz, Child Care Services, all documents in Part A other

than those identified as having been received prior to admission in the Affidavit of Ellen Lynch.

21. The information set forth above is true and correct to the best of my knowledge, information, and belief, and the letters attached as Exhibits A and B are true and correct copies of official records at the Children's Unit.

(s) Marcia Murtagh, M.S.S.
Marcia Murtagh, M.S.S.

Subscribed and sworn to before me this 11th day of April, 1978.

Mary C. Jarrell
Notary
[Notarial Stamp Illegible]

UNITED STATES DISTRICT COURT EASTERN DISTRICT OF PENNSYLVANIA

Case No. 72-2272

Institutionalized Juveniles, et al.

vs.

Secretary of Public Welfare, et al.

DEPOSITION of LINDA L. GLENN, a witness called on behalf of the Plaintiffs, taken pursuant to notice before Cindy Marie Hansen, a Notary Public in and for the Commonwealth of Massachusetts at 190 Portland Street, Boston, Massachusetts on April 7, 1978, at 4:00 p.m.

Appearances:

David Ferleger, Esquire, 2321 Sansom Street, Philadelphia, Pennsylvania, on behalf of the Plaintiffs.

Robert B. Hoffman, Esquire, Deputy Attorney General, Department of Justice, on behalf of the Defendants.

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(2) STIPULATION

It is stipulated and agreed by and between counsel for the respective parties that the reading and signing of the deposition by the witness be waived.

LINDA L. GLENN, a witness called on behalf of the plaintiffs, first having been duly sworn, on oath deposes and says as follows:

Direct Examination

BY MR. FERLEGER:

Q. Miss Glenn, what is your current occupation?

A. Assistant Commissioner for Mental Retardation for the Department of Mental Health, Commonwealth of Massachusetts.

Q. And are you the administrative head of Mental Retardation in Massachusetts?

A. Yes.

Q. So the Assistant Commissioner title involves a commissioner who covers more than Mental Retardation?

A. Right, the Commissioner of Mental Retardation, Mental Health, Drugs, Childrens Services, whole thing, under the commissioner as an Assistant Commissioner for each program area.

(3) Mr. FERLEGER: I'd like to have this marked as Exhibit A, Vita.

(Exhibit A, for identification, VITA of Linda L. Glenn.)

Q. (By Mr. Ferleger) I'm showing you Exhibit A. Can you identify that for the record, please?

A. This is my resume, March of '77. It is not totally up to date.

Q. As of that date, does this resume reflect generally your employment and experience in the area of mental retardation?

A. Yes, it does.

Q. Could you just briefly review that for us, your general employment and experience and we'll let the resume speak for the details?

A. Yes, okay. You want educational experience, or just employment—

Q. Yes.

A. I have a Masters in Special Education for the mentally retarded, a Doctorate without dissertation completed, everything else is completed in educational administration and business administration. I have worked about ten years in the field of mental retardation, first full time after part-time jobs while in school was the (4) Director of Research and Management for the Greater Omaha Association for Retarded Citizens. There I helped develop one of the first comprehensive community-based agency for the mentally retarded. Second full time job was the same position, Director of Research and Management for the Eastern Nebraska Community Office of Retardation, which was an agency that grew out of the Greater Omaha Association, a larger five-county comprehensive program for the mentally retarded, and all of Eastern Nebraska.

I returned to school and worked as a co-Director of Technical Assistance Unit attached to the University of Kansas and the University Affiliated Facility at the University of Kansas which provided technical assistance to all programs in Kansas that served the mentally retarded, all the community programs as well as institutional programs.

Q. When you returned to school, you didn't mean as a student?

A. No, I was a student in a doctoral program there and working as a co-Director on the Technical Assistance

Project. From there, in 1974, I became the Director, Executive Director of the Eastern Nebraska Community Office of Retardation back in Omaha again.

(5) In 1976, I came here to Massachusetts to become Assistant Commissioner.

Q. Could you describe your general duties and responsibilities in your present position?

A. I am responsible for the development and operation of all programs that are sponsored by or funded by the Commonwealth of Massachusetts for the mentally retarded. This includes eight large state operated facilities for the mentally retarded; it includes a system of community programs that are operated by 40 area offices that are part of seven regions. We have the state divided into, that is, developing into a comprehensive system of community residential programs and have a variety of different types, so individuals can move along and continue services, day programs for adults, sheltered workshops, activity centers, early intervention programs, respite care programs, and other support services for the mentally retarded.

The responsibilities include, well, the objectives are to not only develop comprehensive community programs at each of the areas for any mentally retarded person who needs service, but also returning people from the institutions of the state to those community programs.

(6) In addition, I have responsibility for licensing all programs, private or public, that are for the mentally retarded, and for insuring compliance in all the institutional services to Federal regulations.

Q. What is the approximate budget of your office, the Division of Mental Retardation.

A. This year, it is a little over $100 million.

Q. Are you familiar with or do you have any experience with mental retardation and mental retardation administrative systems in other states besides Nebraska and Massachusetts?

A. Yes, I do.

Q. What way have you gained that background?

A. I've consulted with many other states in various categories or various reasons, both state-wide planning efforts, local planning efforts, the development of systems to get people out of institutions, the development of comprehensive systems of community services, technical assistance as well as involvement in those plans. I'm a member of the Willowbrook Review Panel, appointed Page which oversees the Department of Mental Hygienes activities in the state of New York relative to their consents agreement for Willowbrook institution which effects the entire state of New York. The class members from that 5,300-bed institution are now in almost every facility in (7) the state, so we oversee the services in that state.

I have been a consultant for several years for the National Institute on Mental Retardation in Toronto and helped them devise systems in Canada for the development of programs.

Q. And in the states that you referred to and mentioned in your resume, have you visited institutions and community facilities for the retarded in those areas?

A. Yes.

Q. Would that include Pennsylvania as well?

A. Yes.

Q. You visited community facilities in Pennsylvania?

A. Yes, I've done a lot of work in Pennsylvania. In fact, one of the things that brought me in contact with

a lot of institutions as well as a lot of community programs is I helped devise an evaluation system used widely now throughout Canada and the United States, and in the six years of development of that system, we've evaluated, and I personally evaluated, hundreds of different programs to refine that instrument as an evaluation tool.

Q. That is—off the record.

(An off-the-record discussion was held.)

Q. (By Mr. Ferleger) That's the PASS system?

(8) A. Yes, it stands for the Program and Analysis of Services Systems and I have evaluated quite a few services in Pennsylvania on that system. In fact, they use it widely. I trained, I had three different week-long training workshops in Pennsylvania several years ago to train all the Pennsylvania staff.

Q. The Department of Public Welfare in Pennsylvania uses that PASS System?

A. Yes, they do.

Q. Do they use it to evaluate facilities for the retarded in Pennsylvania?

A. Community residential programs, right, yeah.

MR. FERLEGER: Mr. Hoffman, we would submit that Linda Glenn is qualified as an expert in the area of mental retardation, care and rehabilitation of retardation institutions and community care for the retarded in the United States. Do you have any objections to her qualifications?

MR. HOFFMAN: Without admitting all those areas are necessarily relevant to this court case, I would certainly agree she qualifies as an expert in those areas.

Q. (By Mr. Ferleger) Miss Glenn, could you tell us please generally who are the mentally retarded

in the United (9) States? What kind of people are they, how many are there, just what kind of people are we talking about?

A. The commonly used prevalence rate for how many people are mentally retarded in the United States is about 3 percent. That is, that has been used historically from some incident studies, prevalence studies done years ago and it still has not been challenged. Three percent, I guess, of the population of the United States right now would be two or three million people, so you are talking about a very large number of people. That 3 percent, however, is made up of a variety of needs of individuals and severe levels of retardation. The large bulk within that 3 percent are the more moderately handicapped persons.

Q. How many is that large bulk?

A. Oh, at least 80 to 85 percent of the mentally retarded are more mildly handicapped persons that don't need a lot of special services. They can live in the community typically without anybody knowing they were mentally retarded unless somehow in some system they've gotten labeled or institutionalized for some reason. Only about 5 percent of the mentally retarded are in the categories of what the professions call severely and profoundly retarded.

(10) Q. And the remainder are typically called moderately retarded?

A. Yeah, moderately retarded.

Q. And what proportion, if you know, of the mentally retarded are in institutions?

A. A little under 200,000 people are, I think, in public institutions right now.

Q. Are people of all retardation levels to be found in institutions would be defined moderately retarded?

MR. HOFFMAN: Objection.

Q. (By Mr. Ferleger) Would we find moderately retarded, mildly retarded people in institutions?

MR. HOFFMAN: Objection, the case focuses on Pennsylvania, and in addition, I don't they we've been given any foundation from Miss Glenn's information on that point.

Q. (By Mr. Ferleger) Answer the question, please?

A. Yes, there are mildly retarded people in all institutions.

Q. Including Pennsylvania, as far as you know?

A. As far as I know, yes.

Q. What is the procedure that professions use generally for identifying who the retarded are?

A. Well, unfortunately, they still—the main test is an IQ test that the professionals use to diagnose somebody as (11) retarded or to talk about what level of retardation they are. That, however, is not appropriate. The definition of mental retardation takes into account three different factors, IQ being only a factor that cannot be used alone. IQ has to be looked at in conjunction with the adaptive behavior of an individual as well as what stage in that person's life did he develop a problem in both the IQ and adaptive behavior. The standard definition used by the American Association on Mental Deficiency is a person would have to have substantial intellectual subnormally as well as impairments in adaptive behavior that originated in the developmental period. Person's live, in other words, it couldn't be an

adult that had a car accident at age 20. He wouldn't be considered mentally retarded because he may have become brain damaged. He would be considered a person that had been injured.

Q. Could you tell us, to help us learn some of these terms, what years that developmental period includes and what adaptive behavior means?

A. It is commonly considered the developmental period being birth to approximately age 16. Adaptive behavior is whether or not that person has learned to manipulate his own environment. Can he get along in society, does he (12) know how to care for himself and to socially be accepted in society by his behavior, has he adapted to the demands of his environment. It is very often that a person with a low IQ can get along in society. You do not have to have a high intellectual quotient as measured on standarized tests to be able to live in the community even by yourself, to navigate that community, to be able to hold a job and be self sufficient.

Q. Well, isn't there, as I think many people believe, some relationship between a person's IQ or level of retardation and whether or they not are found in an institution?

A. No, not at all. The people you find in institutions now, the reasons range from the parents don't want to let them come out or inappropriate reasons that they have been put in there.

Q. So we would find severely and profoundly retarded people living in the community as well as living in institutions?

A. You'd have the same people living in institutions living in the community, too, exact same people with the same needs and same impairments. It is circumstantial as to whether or not they have ended up in institutions.

Q. Regarding this process of identifying the retarded, you said IQ would be an insufficient indication by itself of (13A) the mental retardation. Could you describe whether and how mistakes are made in identifying whether someone is mentally retarded?

A. Well, there are many mistakes. The most common one historically has stemmed from the fact they have been associated with certain characteristics of individuals who are thought to have mental retardation. For example, at birth, it used to be if a child was born with a physical characteristic of a Down's syndrome child, mongoloidism, which can be noted at birth, the person has been assumed by many pediatricians and other professionals as automatically meaning mental retardation. That's been found not to be true. The fact that people have not had experience with individuals that have been allowed to live in the community that have Down's syndrome, that are allowed to have developmental programs and meet their needs, they hadn't seen that it is not necessary that Down's syndrome people are mentally retarded. They have to be given that opportunity.

Q. What other kinds of mistakes are made and how?

A. A lot of other handicapping conditions can cause the person to test on tests lower than their intellectual capability. Deafness is a good example. They have evaluated a lot of people on standardized tests and (13) thought they were severely mentally retarded and found out years later the problem was deafness.

Other problems are physical handicaps. Some people are born with multiple physical involvements that

don't allow them to have normal motor movement, normal speech patterns, normal capability to communicate and since they haven't been able to communicate or to walk like other kids or behave like other kids physically, they have been labeled as mentally retarded.

Q. If I recall correctly, as reasons for mistakes or errors in identification of the retarded, we have inappropriate use of IQ tests without consideration of other factors, which define mental retardation, physical problems such as deafness or other physical handicaps, assumptions that are made about somebody at birth or some early point—

A. Developmental speculations that are wrong.

Q. Have we generally covered that area?

A. Well, treating it that way makes it sound like IQ is a static indicator. That's a basic problem. A person may test low both on adaptive behavior and IQ and unfortunately is placed into an institution or some other non-developing-type atmosphere and he doesn't grow. But if he is placed in a facility that has (14) appropriate programs and typically kept in the community, then he grows every year. You can't say because he is diagnosed this year as mentally retarded, then he will be the same next year and the year after. That's a dynamic type of diagnosis.

MR. HOFFMAN: I'd like to interject for a second. I'd like to place a general objection on the record, that I think most of this testimony seems rather far afield from what I understood the Court asked the scope of this inquiry to be, which was that the mentally retarded and the mentally ill raise similar questions with respect to admission procedures to residential facilities.

MR. FERLEGER: That's right, the purpose of this obviously is to inform the court as to what mentally retarded are, who they are, where they are, in order for the court to determine whether or not there are differences, when that would require differential treatment.

Q. (By Mr. Ferleger) So people grow out of being mentally retarded in some cases?

A. Oh, in many cases, sure.

Q. And what many of us learned or absorbed as young people growing up, that someone who is mentally retarded has a (15) a mental age of a six-year old, is just going to be that way for their entire lives, is that a correct assumption or incorrect?

A. That's correct. In the past ten years in the field, we have learned that even people that have been diagnosed as serverely, profoundly mentally retarded, multiply handicapped in the past they have put them in institutions and haven't been given opportunities to grow. They laid in bed and looked at the white ceiling.

Q. I'm not sure if you misspoke or not, but it is not correct those people will remain the same?

A. If they are only given the opportunity to lay in bed and look at the white ceiling with no stimulation and no experiences, they will probably remain at that level of capability. But we have learned, giving them developmental opportunities in a normal, active environment, that many of the people are not mentally retarded, even those that we have thought were profoundly retarded.

MR. HOFFMAN: I'd like to make another objection to any of Miss Glenn's general comments, particularly on the quality of institutions and on institutions, on two grounds. First, that I think the

Court has ruled that the general conditions to be irrelevant and that Miss Glenn (16) is speaking generally, not in reference to Pennsylvania. That would seem to be irrelevant to this inquiry.

Q. (By Mr. Ferleger) Miss Glenn, so the record will be clear, if we come to any point at which your discussion on the mentally retarded somehow does not apply to mentally retarded people who happen to be in Pennsylvania, would could let us know?

A. Yes, I will.

Q. Thank you.

In terms of where the retarded are, could you tell us, if you know, what proportion of the retarded can be found in institutions and what proportion in community programs?

A. Nationally, only about 10 percent of the mentally retarded are in institutions. The remainder are in the communities.

Q. We have been using the term institution and community for awhile, I expect we will be for the rest of this deposition. Could you give us a working definition of those terms?

A. The statistic should clarify that I gave you, was talking about public operated institutions, so I don't want that to be confused with my definition of institutions. That's one type of institution, but the best definition of (17) institution that I've seen used and I use myself that an institution is any residential facility which is larger than a large family would be and exerts more controls over the individual than a large family would exert. The communities would be those—well, the larger environment surrounding those places that don't exert controls, that are normative, environments, either the person living in his own home or the person living in small residential facilities in foster homes and different types of specialized, but small, dispersed programs that are normative, normal houses, attending day programs away from their places of residence, being able to utilize community recreation, community social programs, where the life of the individual, the pattern of life and the rhythm of life is typical as it is for a person that is non-retarded. That would be the community definition.

Q. And those community facilities exist in, would you say all or most of the states in the United States?

A. There are community programs in every state in the United States, yes.

Q. And I take it from your earlier testimony you've seen at least some of these in Pennsylvania?

A. Quite a few in Pennsylvania, yes.

Q. With regard to institutions, could you describe for us, (18) please, the general nature of life in institutions and the dangers of life in those institutions, paying special attention to the adhered declaration of liberty that is involved in institutions?

MR. HOFFMAN: Objection relevant to the last qualifying phrase of Mr. Ferleger's question.

THE WITNESS: Well, institutions are inherently inwardly oriented and self-contained, which makes it even more difficult to return people to the community or have people learn normative ways of life because it takes away all the experiences from an individual that any other person would receive by either growing up in his own home or being provided a service in the same community or with other people that are in the community that are non-handicapped. What an institution does, unfortunate-

ly, is take each individual and instead of really looking at which areas of that person's life, there are really four spheres in anybody's life, and deciding which areas that person needs assistance in or training in or even some cases protection in, it automatically protects all four areas of the individual's life and over-protects in the sense of not letting him learn the normative experiences in other aspects. It shelters the home or residential area of a person's life, (19) the developmental area of a person's life, whether it be education or training or vocational types of opportunities, the whole learning experience, it goes on for a person to have recreation activities in the community, and other social activities, using banks, learning how to shop in the community, learning how to just navigate the types of recreational and social opportunities as other people.

The institution by sheltering all four areas, doesn't allow individualization. Some people may need assistance in their training program. They may not be able to work by themselves, now, in competitive employments; because that's true, that's no reason to shelter him in his residential area, in his recreational opportunities and experiences, or any other social type of opportunities. It is—the same thing goes for people that—some people do not even need assistance in living by themselves or living in a supervised setting, but he also may be able to work in a normative type of setting attending normal community activities and recreation and social, but an institution extracts, takes away liberties and opportunities in all areas once a person is placed there.

Q. Finish.

(20) A. There is really a whole lot and I have problems that institutions per se create. I could go through those. Some of the ones, the most important to anybody's growth, an institution automatically takes away by the fact of institutionalization. I could cover those.

Q. Please.

A. There are really two major growth dimensions or things that are important to anybody's growth, whether you are retarded or not. One of those things is model. Most young children and all the way up through your developmental period as well as in adulthood learn, not only from your program or what type of intensity of treatment you are given but you learn from peers. You learn by being associated with groups of other people in all types of experiences throughout your life. Unfortunately, what happens in an institution, is once a person has been committed to an institution or goes to an institution, all experiences by other peers that are non-handicapped are taken away. So you have a child in an institution that his only other models to learn from are other retarded kids or other handicapped kids. So what happens is the kid learns handicapped behavior instead of normal type of behavior. You can see this when you first send normal kids to regular pre-schools or first grade. They (21) all of a sudden start picking up behavior from other kids that the parents have never seen before. This happens in institutions, and you end up with a lot of maladapted behaviors, lots of stereotype behaviors, inappropriate social behavior, that he has picked up because he is around other people with similar problems or worse problems. You have common in-

stances where a child will have a certain problem, and maybe the place, like head banging or some other behavioral problem and the facility may be able to work on that particular problem; but because he associates only with other handicapped people, with similar other problems, he replaces that behavior with worse problems or with different problems but just as bad. He may lose his head banging but pick up biting or because of the depravation in the environment in institutions, a lot of individual stereotype behavior, you'll see kids rocking, you'll see kids spinning around or playing with their hands in front of their face all the time. That's institutional type of behavior so the modeling phenomena is most important.

To achieve this the programs both physically and socially for handicapped and mentally retarded kids have to be integrated into the community where the (22) opportunities for learning with peers and from peers is enhanced and not extracted from that person's environment. The social opportunities, the experiences, you cannot expect a child to learn to live in the community or to behave and respond as others learn to do as they grow up if you have extracted all those experiences from you.

Q. Go on.

A. It could be a long one, if you want a whole answer. The other largest reason for growth of anybody, not just retarded people, is the power of expectations on the individual and the power of an experience growth which is dictated by how many developmental challenges and opportunities the person is given. A person's growth is dictated by these challenges and the fact that he constantly has the opportunity to learn new things can be expected to do new things, he may fail some,

but that's a learning opportunity, too. What institutions have done is take away not only the developmental opportunities and experiences, but created an environment where the expectation level on the staff that work with a person is very, very low. They know he is handicapped. They know he is mentally retarded as soon as he enters the facility, so they (23) don't expect him to act normal, so all of a sudden he doesn't act normal. He acts different from normal people. That reinforces the fact that they knew that he was different so they continually treat him differently. Sort of a feedback loop of role expectation.

There are other problems with the facilities being too protective that cut down on developmental growth challenges for the person. The problems, when you have large numbers that you cannot individualize, every person learns differently, every person learns at a different rate, every person needs different types of emotional, social, as well as educational opportunities. When you treat people in masses, there is a tendency, and there is a lot of research to show this is common, to have a very dehumanizing environment by treating people, everyone alike, sort of like the fortification in the Armed Forces where everybody was treated, upon entrance into the Service, exactly alike same haircut, same clothes, the way they have to line up, then, that happens in the institution.

Q. So, for example, Irving Goffman's book, *The Silence,* would apply to mental retardation facilities as well as mental health facilities?

A. Definitely; in fact, it has a more overpowering effect (24) on a mentally retarded person because the person has not in some cases learned to fend off some

of the problems in the institution and the dehumanization features for himself whereas a person in a mental health facility or corrections facility may have learned that. It also has a much more powerful effect to institutionalize a mentally retarded person because it has been an indefinite placement and there is a long history of institutionalization by the majority of people there, get placed in an institution for 20, 30 years before they have the opportunity for something else. So you are talking about a powerful, long-term effect on the individual's life.

MR. HOFFMAN: Continuing objection to all the previous testimony and, I guess, what will come as being outside of the deposition requested by the court.

MR. FERLEGER: Don't object to what is to come. You haven't even heard it.

Q. (By Mr. Ferleger) Miss Glenn, could you describe whatever stigma or lingering discrimination and post-institutional life there is for the retarded person who is or has been in an institution?

MR. HOFFMAN: Objection, relevance.

(25) THE WITNESS: There is tremendous stigma for having been institutionalized. The image in a normal person's mind of a person who has been institutionalized is one of very aberrant behavior, of dangerousness. It is not one of somebody in need of just care or training, which some professionals think is the institutions' purpose. But the image is someone of a person that had to be put away to protect the community or to protect himself.

Some one—it is also—the very self image of the mentally retarded person is hurt by that. The fact of the stigma really hurts the person's later integration into the community.

Anybody who knows he was institutionalized fears his behavior, fears that something is going to happen to their children in the community or they are going to get robbed or some other problem just by the fact of institutionalization.

The discrimination that is placed on these people is quite traumatic.

Q. Hypothetically, if we had two retarded individuals, both of whom were at the same level of retardation and had the same physical handicaps and experiences, if one of them had been in an institution earlier in his or her life and the other one had not, could you (26) evaluate for us their chances of participation in community life, in work or in other areas?

MR. HOFFMAN: Objection, relevancy.

THE WITNESS: Certainly. One whole area, in answering that question, would be that within the institution the person would not have learned normal culturally appropriate and age appropriate dress, social behavior, how to relate to people, how to relate to the opposite sex, he would have problems in dealing with other people. He would stand out in a crowd. He might even talk louder because he has had to get used to screaming over the noise of others. He would be pointed out in a crowd and avoided because of the inappropriateness of his behavior, not allowed to participate in certain activities,

not allowed in many cases to be in competitive employment because of this type of behavior that he both learned in the institution and never learned to develop appropriate because he was in the institution, in the community.

The other would be more of a discrimination placed—the fear I was talking about, not wanting a person that used to be in an institution to be employed in a certain place because of fears of his behavior or certain acts of his would be either disruptive or stealing (27) or criminal or something.

Q. How realistic are those fears? Are the retarded generally a dangerous class of people?

A. Oh, no, that has been an old myth where people have not understood the difference between other types of people considered deviants, criminals, some people that are severely, emotionally disturbed, acting-up behavior. Mental retardation is a slow person.

Now, some of the behaviors that are learned within institutions sometimes are a problem, some of the stereotype behaviors that I mentioned, because of lack of activity, there is some aggressive behavior to get attention. There are some people with self-abusive behavior that's developed. But the fact of mental retardation only connotes a slowness in the learning process.

Q. Not a predisposition to dangerous behavior?

A. No, not at all.

Q. I hope we can get your assistance on qualifying something that I think is rather important. In your description for the last few moments of what institutionalization does to people and the effects on people, are you just talking about public institutions for the retarded or are you talking about institutions, the broader

(28) definition that you gave us earlier? In other words, the effects that you are talking about to be found in both public institutions and, let's say, the large private institutions where many families pay a lot of money to—

A. Definitely.

Q. Which way?

A. That the effect of institutionalization is the same whether public or private, if in an institution. There are varying effects mainly based on size. If you get down to a ten-bed institution, typically the research has shown that the powerful effects of the institution are not as great as a hundred-bed institution. But when you get larger than, you know, ten, 12, 15, 20, the same powerful effects of very large institutions apply to smaller institutions, too.

Q. So, for example, are you familiar with the Deveraud Foundation that runs some residential institutions?

A. I know them by—I haven't evaluated the programs, but I know of them, yes.

Q. From what you know of those facilities, would they fit into your general classification of institutions?

A. Yes.

Q. Would you tell us briefly, historically, how did these (29) institutions come to develop for the retarded?

MR. HOFFMAN: Objection, relevance, outside the scope of the deposition.

THE WITNESS: Why we have institutions, why institutions originally developed and why we have them today is very interesting because they developed only in response to an archaic perception of the mentally retarded. It used to be in society that the mentally retarded were perceived as non-

developing organisms, people that had no potential at all to develop. We have learned in the past 10, 20 years that this is not true. Persons that have mental retardation have just as much capability of developing as anybody else and on a continuous basis to develop, so that old reason for having institutions at all was knocked out years ago. Other perceptions were that mentally retarded persons, just because of mental retardation, were dangerous to society, were a menace, needed protection for their own sake, as well as to protect society. That perception also has been just torn apart and proven time and time again over the past 10, 20 years, not to be true. Thus, there really is no continuing reason for institutionalization because we have learned that mentally retarded people not only do not fit these old role (30) perceptions at all with our new learnings, and we found that the research shows that their development and growth capability is much enhanced if they are never institutionalized and certainly hurt when institutionalized.

Q. Perhaps you could just summarize in a sentence or two why it is that, as your testimony has indicated, it is your expert opinion that institutional care is not preferred and that community care for the retarded is the option that ought to be chosen?

MR. HOFFMAN: Objection, relevance?

THE WITNESS: The goal any social agency is going to have for an individual they take into their care is the training and habilitation of that person to allow him to take on as much independence as possible for that person, to learn to live in the community as independently as possible, even though, though some people will need some level of supervision, that goal cannot be achieved in institutions. You cannot learn to live and to manipulate in your environment by living in an institution. It is just totally the opposite. You don't learn how to use the normal things anybody else does, stores, banks, you don't learn how to cross the street. When you get out in the community, you may get injured trying to cross the street. You (31) cannot learn those basic goals that we would have for independence when you are totally segregated and apart from the rest of society.

Q. Could you list for us the reasons that despite this knowledge which has been in existence for many years on the nature of institutional care, why institutions seem to be hanging on in our society?

A. Oh, there are many, many reasons.

MR. HOFFMAN: Objection, relevance again.

THE WITNESS: They range from people, even professionals, being ill informed about the appropriateness of certain types of services and the effects of certain types of services on individuals. You still have some pediatricians who do not get training at all in mental retardation advising parents that their child should be institutionalized because they don't realize that we have come so far in this field, that the developmental potential and the expectations on a person can be so much greater than just needing custodial care. You have still the attitude of some people that people that are different in a whole variety of ways should still be put out of

sight, out of mind; so that society will not have to bother with people that are different, you have a system that has developed institutions (32) across this country that have developed a large power base. You have staff that work in institutions that have their own egos involved, that only they can do the right thing and that they are—well, in fact, they're perpetuating themselves because they feel they are doing the right thing, they, too, being ill informed. Typically a lot of old guards that still hang on to the old beliefs about segregating the handicapped, you have power bases having been developed through the history of institutions and bureaucracies by unions and civil services and others that the main purpose is to protect the jobs. So we have not been able to faze out many institutions because of these types of external demands. The fact that institutions have been in some states, almost all states, in the past and in some states still today, the major state funded program, you have a situation where they look more secure where parents can trust that the state will fund that institution every year, thus they want that security for their son or daughter, even if they admit it is not the most appropriate placement. They don't know if they had the person live in the community in some other type of program or by himself that the state will take care of him if they die. So it looks like a (33) more secure thing because you can see the big monument on the hill with the smokestack and water tower and you know it will always be there. So it has been a security thing for some people.

Q. Could you tell us please what variables are involved in—where it is that a retarded person receives care or habilitation? Is it the level of retardation? Are there other factors involved? And if so, what are they?

A. Well, there are many reasons why a person needs service. On the one hand—

Q. Maybe I should bring that up. First, is it the level of retardation?

A. Not at all, no.

Q. Aren't there some people who are so retarded that by the very nature of their retardation that they ought to be in an institution out of the question?

A. No, none. There are three global areas of why a person would need any type of out of home type of placement, to be out of his own home, and there are a lot of sub reasons within each.

Q. Why don't we cover them one at a time.

A. Okay. Let me list the three, then I'll go into it.

These three reasons are typically a problem in the family, the family, for any number of reasons. And I (34) enumerate those, as having a problem. They cannot keep the child in the home, or there is a death in the family. There is too many other kids in the family and since this one has a label, the retarded kid has a label. There's the kid that has a place to go, there is no family, some are abandoned kids, kids that belong to social service agencies like Welfare because they have been removed from the home because of abuse. So a problem in the family that has nothing to do whatsoever with the child's clinical or educational needs is one whole category.

The second category would be a problem with the individual, mentally retarded person himself. This is the

most minor area. A problem like that may be something like the child has developed extreme behavior problems or is extremely hyperactive and maybe sleeps only two hours a night and bounces off the walls the rest of the time. That builds up such a stress in the family, inability to keep that child in the home without assistance, and when there are no resources to give that family assistance, then that person may need out of home type of service.

The third major area are things in the community. The community or, let's say, the surrounding neighborhood (35) of a person that's mentally retarded living at home, may not like certain of the differentnesses of that person, which may be just his looks, it may be some social behavior. A lot of pressure from a community causes a family to have to make a decision, either move from that community or have the child live somewhere else because of pressure from that community.

Q. Considering these factors that you're mentioned, the communities, individual, the family, and dynamics among those factors, do factual conflicts or disputes arise, and if so, could you give us some examples?

A. Quite a few factual, in several broad categories, conflicts come about all the time. A lot of these are between the individual or the family and the community. For example, there are a lot of cases where a community will pressure a family or social agency to institutionalize, say a young adult retarded person because they say he is creating problems in the community. When you really take a look at the situation, you typically find that what has happened is the individual can have lesser capability than some of his peers of that age, let's say, a 25-year old man. He will still be in the developmental stages of someone that may be is 13, 14 years old or ten or 12,

and he may have enjoyed doing those types of activities and (36) maybe doing it with other ten-or 12-year old neighbors in the community. The community gets very upset, that they think this young man, all he wants to do is play, is molesting their sons and daughters that are younger than him in the community.

Q. That may be a perception—

A. It is an inappropriate perception.

Q. Appropriate or—by inappropriate, you mean in error?

A. Yes, in error, definitely. Those things don't come out, though. Just the pressure builds up on the family from a lot of different directions and they think it is best for everybody to have the person institutionalized.

Q. Since we're focusing on juveniles, that could also be true of people 18 and under?

A. Certainly.

Q. Those kinds of factual—

A. Certainly. Parents of normal kids that have not had exposure to mentally retarded people really get upset when somebody different is—even of peer age—is playing with their children in the community or if they are acting a slight bit different. They don't want their children associating with that person. Typically, there is no real problem at all. It is an understanding of the range of differentness.

(37) Q. would it be correct to say that factual disputes can arise in all the various contexts you described regarding the communities, the individual, the family factors, for institutionalization?

A. Oh, certainly. Definitely. There are a lot of —it is hardly ever a problem in the individual or with

the individual that creates the situation for institutionalization. I mean, it is a whole range of things involving stress on the family for any number of reasons in many instances that doesn't even involve the retarded person, the stigma on the family because of historic problems of acceptance of differentness by other people. You have a value conflict there of the parents being ashamed that they have a retarded person in the family versus the retarded person or having any needs.

Sometimes families can't afford the care of a person that has minor, more special needs than the normal kids in the family, or there are no resources to help that mother learn to deal with the social agency that they have to deal with to get other services for the retarded person. The level of expectation, the doctors that first diagnosed the kid, told the parents that he would never grow. It is a low level of expectation out of ignorance on professionals' part.

(38) Sometimes where a person lives, there are no services so they feel they have to send their son to the next largest town a hundred miles away to receive services.

Q. Well, coming from what you are describing, I'd like to ask you, Miss Glenn, whether you have an opinion on whether or not parents should be depended upon to make the decision on whether or not their child should be in a mental institution?

So the record will be clear, when I say child, when we speak about juveniles, we are speaking of people 18 and under.

MR. FERLEGER: Off the record.

(An off-the-record discussion was held.)

(A brief recess was taken at this point.)

Q. (By Mr. Ferleger) And also of people who are retarded?

A. Okay.

(The last question was read back.)

THE WITNESS: From my experience and from—the literature is quite extensive on problems parents have when they have a mentally retarded child. I certainly would say parents should be involved in the process of decision making but certainly not the person that makes the decision.

(39) The literature, most of it, really talks about when a person, a family, a parent learns that they have a retarded child, either at birth or at any time during that child's life, they learn the person is retarded. And then what they have to deal with in the sense of their own emotional state as well as the stress in caring for somebody that needs extra attention, as well as the stigma that goes along with society's acceptance of retarded people, that they emotionally should not be the ones to make a decision. They go through various stages of what professionals call novelty shock, where they have expected a child to be normal, who they planned to go to college, planned on him being a doctor or maybe a lawyer, and all of a sudden, their expectations are shattered about what their child is going to be able to do. And there is a greater emotional stress which often results in them not wanting to deal with it, and not having any support to deal with it, so that rejection of the child starts and inappropriate and certainly unneeded institutionalization results from that.

The value conflict is another one. There is a lot of literature on where because society doesn't accept a person, the family really does not want to deal with them being a different family in the community, and (40) rejecting the child for that reason.

These first two, however, are things that, with support in the communities, parents get over. But unfortunately, the typical response to these—get over very quickly—but the typical response has been to not deal with that and institutionalize the child.

Then there are problems with reality stress situations of value to deal with the child that is different. But even aside from those emotional difficulties that parents are constantly going through with pressures from other people in the community, pressures from relatives, you know, not to say they have a retarded person in the family, not having the —being able to have the same type of expectations on the child and inappropriate idea often called by professionals that the child will never grow or never be able to talk or never walk.

Q. It is your testimony that you have heard of actual cases in literature, documents, cases where pressures like you mentioned from family members, not to admit that there is a child in the family retarded, have resulted in institutionalization?

A. Certainly.

Q. And where the novelty shock, the value conflict, the (41) reality stress as you have described, those have resulted in institutionalization?

A. That's been one of the main reasons for institutions. There are others, more concrete types of reasons

that, again, hardly any of them relate to the needs of the individual child. Conflicts between parents, conflicts because of the guilt of what is appropriate for the person or conflicts in their capability to cope—any child is hard to raise for a family and for a family that hasn't raised children and there is a lot of projection to a handicapped child that he is creating the stress problems in the children. If they are created by other reasons, other problems, financial problems in the family, it is often projected on to a handicapped person. It is a stress laden time for parents to try to insure they are receiving the right services and they are often at the end of their rope and think that maybe if the child is out of the home in what are typically named schools for the mentally retarded, they think maybe they will get the education there.

I have a retarded brother and my parents thought at one time because they could not get a good educational program in one community that because the institution in that state's name was blank school for the (42) mentally retarded, if they sent my brother there, he would get an education. It was out of ignorance. They considered it, which they didn't do, but—

Q. To what extent does the ignorance of alternatives, including community care, make parents less reliable to be the decision makers on the institutionalization of their children?

A. I was going to talk about that. Because of the wide range of community services that have developed over the past few years for the mentally retarded, even in Pennsylvania, there is a very wide range of community services. But they are relatively new in the past six or seven years—most people only know of the services of institutions, because they have had hundreds of years of

existence. They are the ones that are the most visible physically in the communities because they are large—not in the communities, in the country usually, large facilities. They have been run by the state and if they approach a state for services, that's often the only one they know about, the professionals they go to often don't know of the range of alternatives and recommend institutionalization, unless the—

Let me back up. Most parents don't have even the knowledge of the right professional to go to. Most (43) parents find out from their families that the child is retarded or find out from a school psychologist, once the child enters school. And they have not noted any developmental lags in childhood. Those two professionals, or almost any professionals, unless associated with the service agencies that provide the range of alternatives, only know of institutionalization.

The pediatrician may not have had any even education in the medical school year. That's just starting as a part of a physician's training. He's just learning about mental retardation. That doesn't even include alternatives to institutionalization, so the recommendation to the parents from those most trusted, like a family physician, is often a choice based by someone that is ignorant to the alternatives to that.

Q. Can't parents, when they are speaking with—they are reporting to doctors, psychologist, and other service agencies, about their retarded child, can the parents objectively report the behavior of their child or the condition of their child when the issue is institutionalization?

MR. HOFFMAN: Objection, outside the scope of this deposition.

THE WITNESS: Not always. And the reason for that (44) is more of a—a family is not going to, in the vast majority of cases, even have the thought of institutionalizing their child until they have reached a point of high stress of either not being able to get other services or stress in the family conditions, in the home, that have them seek institutionalization. At that point in time, it is high crisis time for a family, high guilt time, where there is much guilt in the decision making process. And a lot of that gets projected on to their descriptions of the child's behavior or the problems that they have had and they think they won't get any service unless they really exaggerate that this person is a tremendous monster or they won't be able to carry through with the decision that they finally made to seek institutionalization.

So there's a definite problem for that reason. The other problem is that parents typically do not have automatically certain behavioral intervention types of schools, and a parent may have thought they have tried everything to work with the child with a specific problem, but with just a little advice and consultation from somebody with behavioral intervention type of techniques, that that problem could have been resolved of or diminished. So that the alternatives to the parent (45) ever needing to apply for institutionalization have not been exhausted in most cases.

Q. Another alternative for the gate keeper, decision maker function, regarding the institutionalization of retarded juveniles, would be the institutional staff or pos-

sibly various community mental retardation agencies or other referral agencies. You may want to separate those two, but could you tell us your opinion as to whether those institutions and/or community referral agencies should be relied upon to make the decision?

MR. HOFFMAN: Objection, again, outside the scope of this deposition.

I'm just making my continuing objection. The whole issue in this case is who decides. If we can't get an opinion from this expert on why we can't trust parents to decide or why we can't trust institutions to decide or community agencies, then we probably should have been dismissed back when you filed your motion to dismiss a few years ago.

I understood the issue that you could have raised all of this testimony before the Court prior to our hearing on March 31st, but chose not to and instead, I understood that the Court has asked for or permitted an additional deposition solely on the issue of whether the (46) same considerations apply to the mentally retarded as to the mentally ill. I think that should be the scope of this deposition, as I have indicated in objections. I think we have gone far afield from that scope.

MR. FERLEGER: Not at all. The same considerations that were discussed by four of my experts and four of your experts in the initial proceeding are the very considerations that I'm asking Miss Glenn to give us her opinion on as they apply to the mentally retarded. We already have opinions from experts on how they apply to the mentally ill. We're

now getting an opinion on how they apply to the retarded.

Q. (By Mr. Ferleger) Could you answer the question, please?

A. First, there is a basic conflict of interest for somebody in the institution to make a decision about whether or not a person ought to go to that institution. That would be sort of like a store owner deciding whether or not a customer ought to come into his store or somebody else's store. Institutions, as I indicated earlier, are sort of fighting to prove their necessity and justify their existence. All the research in the past 35 years has shown that institutions are not appropriate for the developmental growth of mentally retarded persons, but there are a lot of people that continue to try to justify (47) their existence and the only way they can do that is by having a population. With the move Federally and by states and professions that recognize the inadequacy of this historic institutionalization having a dramatic move toward deinstitutionalization, there is a real conflict where institutions have to have people to prove they should still be around.

Another reason is the institutions, in the vast majority of cases, if not all the cases, would be ignorant of the other alternatives to someone being placed in their institution. Their responsibilities, obviously, would be the operation of that particular program.

Also, the staffs of institutions by the very fact that they work there, think that they are doing the right thing, think that they are the best place for people, and so everybody gets ego involved in what they are doing and have been doing for years and think only they can do the right job.

Thus, an institution staff making a decision would naturally have a tendency toward saying people belong right there in their institutions.

There is also the issue of institutional staff having a mentality of over-protectiveness, really feeling (48) a person has to be brought into the institution and serviced by their staff and protected in that type of environment or the staffs wouldn't necessarily work there.

Q. Would it be your testimony that these phenomena would occur regardless of the goodwill or good faith of the institutional staff?

A. Yes, definitely.

Q. So the influence of the conflict of interest, the ignorance of alternatives, the ego involvement, in your experience, would affect and has affected decisions on admission of particular children to institutions for the retarded?

A. Definitely, even here in my own state, where our policy is to get everybody out of institutions and where I've attempted to hire superintendents that have the same ideology, but it is very hard to find people that want to be superintendents of institutions now because they know it is a dead end street and you cannot get necessarily highly qualified people. I have succeeded in getting these people, but, a change over time, where our policy is to get people out and superintendents start sneaking people in, to make sure they can get the same amount of money next year, same census on the (49) roles, it is a justification of your existence, I guess, type of behavior.

Q. You answered my question with regard to the institutional sphere.

Now, can you tell us your opinion as to whether or not the recommendations of community mental retardation agencies or other social agencies or the reports of a doctor or psychologist ought to be accepted as a decision to institutionalize a juvenile?

A. I think I covered the doctor, psychologist issue a little bit before.

Typically, number one, mental retardation is not a medical problem and physicians are not trained in either mental retardation as a rule or service delivery. They are interested in medical aspects or the symptomology or the syndromes that are associated with the mentally retarded, so the service delivery needs of a person, are not their bailiwick. Psychologists—well, there is a whole range of professionals that do work with community programs and different types of social agencies. I'll talk about social agencies, psychologists to social workers to educators, they, again, don't know all the alternatives, (50) have only had experience as an individual professional with certain types of services, maybe associated with certain types and have their own ego investment in those types of services.

The major reasons, you could not rely on those social service agencies is more one of the pressures on those agencies and the fact that those agencies, the large case loads in almost all cases, the attempt is to find as rapid a placement as you can so you don't have to deal with that person on a 24-hour basis because of the problem, try to find somebody else to be responsible for that person in a quick way, administratively. They use institutional placement as a cop-out for the sometimes difficult job of getting through the red tape of getting an alter-

native placement or developing an alternative payment. Many social agencies are resource-bound in the sense of what they are able to pay for and often institutions are free because they are publicly operated.

Q. They may recommend an institution even though they may be aware that some other alternative would be more appropriate?

A. That often happens. Because either the only thing available, the only thing they know about or they don't have (51) time to deal with the individual aspects of the person's needs such as to match together a lot of resources to make sure it is individually appropriate for the person.

Q. Dr. Michael Ingall testified earlier in this case for the mentally ill children that over-crowded clinics may over-recommend institutionalization. I take it from what you said that that happens in the retardation area as well?

A. Oh, very often, yes. There is often, also, some of our universities are still not putting out professionals that have the appropriate ideology about the more severely and profoundly retarded; most of the universities are still training special education teachers to work only with kids that are moderately, mildly retarded, can sit nicely in their classrooms of ten or 12, don't have more severe problems. So even though they can classify them as a professional in the field of mental retardation, they have not had the experience to see the dramatic effect of growth of a person if he is left in a community. So their recommendation, out of ignorance, would be an institution.

Q. Miss Glenn, I know that since I first contacted you about this deposition, only four or five days ago, you

(52) may not have had time to go over very much material on this case, so I don't know what your answer to this question would be, but have you had an opportunity to read the opinion of the District Court of July, 1975?

A. I have to look at it to see if I've seen it.

Q. I show you a copy of the opinion. See marks on it. But my first question was whether you read the entire opinion or not?

A. Not the entire opinion.

Q. Do you have an opinion, Miss Glenn, on the question of whether or not juvenile mentally retarded persons should be provided a hearing with regard to their institutionalization and whether, at such a hearing, they ought to have the right to notice to counsel, the opportunity to cross-examine witnesses and present evidence, to be present at the hearing?

A. I certainly have an opinion on that, yes.

Q. Can you tell us your opinion, please?

A. When you're dealing with any placement decision, for example, for a mentally retarded person, you are dealing with a life decision for that person. I mean, you're not dealing with like a—typically, in a mental health case, it might be a temporary admission or in a criminal case, it is at least a time limited type of decision. (53) You're traditionally and typically dealing with something that is going to affect that person's life for the rest of his life, even if he doesn't stay in that institution the rest of his life. That is a heavy decision, I mean, that is a decision that the power of it is tremendous. That's one reason it should not be left to the parents solely.

There has got to be some considerations taken into account. There has got to be an adversary type of pro-

ceeding so all sides can be heard. It's got to be totally impartial. I would even say it could be an administrative —couldn't be an administrative hearing. There are too many conflicts of interest to that and there is not enough real prestige to that to bring up all the peers and the type of image that would make people take it as a serious consideration. You are not dealing with something like a hearing that is going to affect one aspect of a person's life, like a Welfare financial assistance hearing, or an appeal or something like that. That only affects a minor thing in an individual's life. This decision on placement of a person is going to affect him for the rest of his life, so there would have to be a hearing, and in my opinion, a judicial hearing because of the image and their proven (54) impartiality and that can really find out the facts, can insure that that person has a service provided to him that matches up with his individual needs with the setting that can both provide those needs in accordance with plans for that person, most appropriately, in the least restrictive setting. It takes away the least number of rights and avoids him of the conflict that would arise.

(55) Q. Did you see any way in which a hearing could harm the retarded juvenile involved—strike that.

Can you see any way in which a hearing could harm the person who is alleged to be mentally retarded and in need of institutionalization?

A. No.

Q. Some people have indicated that the process of participation in a hearing could be very traumatic, perhaps excessively traumatic, for the person.

Have you any opinion on that question?

A. I think I'd see it the opposite. Just the dignity given to a person and the self-worth gained by the fact

that a large number of people would be interested in him getting the appropriate service, the right to be represented by somebody that is going to take his interest first and foremost, even if those interests conflict with the parents' interests, I see more of a dramatic positive side to the person in that hearing.

Q. I want to make sure I heard three of your words correctly.

You said self-worth gained, g-a-i-n-e-d?

A. Yes.

Q. Would a hearing be, in your opinion, either an undue interference with a private family matter or (56) would it contribute to some possible breakdown of the family?

MR. HOFFMAN: Objection. I'm not sure I think that's within the areas in which Miss Glenn has been qualified as an expert.

Q. Understanding, of course, we are only talking about mentally retarded people?

A. Yes, I see it as exactly the opposite. When a family goes through the problems of decision making that I mentioned before, there is much trauma of deciding whether or not to have the child removed from your home to go anywhere, guilt feelings of the parents, like he is shirking his responsibility and not really knowing whether or not his decision is right or not, and that feeling of never knowing if you made the right decision lingers on with parents for years and years and years and can create its own problems of internal family trauma.

In fact, it hinders even future family involvement with that child because every time they see the child when

they go visit him in the institution or wherever he is, it surges up all the old guilt feelings and indecisiveness about whether or not they made the right decision.

(57) A hearing, on the other hand, would answer that for the parents, you know, would make sure the parents felt comfortable with the decision, the fact that other people were involved in that decision, it was heard on both sides, they brought in other testimony, that there was finding of fact.

Also it would cut down on the trauma in the family if there was internal, which there often is, conflict in the decision making.

Let's say—well, in many cases, the father will say let's institutionalize the child, the mother will say no, the father will win, and it will create problems in the family for the next 50 years. So an impartial hearing with fact finding and decision making can decrease the trauma, not increase the trauma.

Q. Could you list for us what benefits a hearing would have for the retarded juvenile and his or her family?

A. I think I just listed a few.

Q. Well, could you list them again?

A. Well, you've relieved the parents of the sole decision making of their own without assistance that may create the problems I mentioned. You relieve the institution of the burdens of those decisions, too. You (58) do have the fact finding, if there is the conflict we talked about earlier, and the reason for someone coming to the hearing for a commitment procedure, you have a forum to find out what other alternatives there are, you have a forum for actually finding out what the reason is for

the problem or for the potential commitment so that maybe other resources can be applied to that, and you can determine what the individual really needs.

It would, again, enhance the self image of the person, and I guess you could—to me, one of the most important things would be if they are really considering institutionalization for the first time, there would be a place where the institution would have to prove that it could meet the needs of those individuals. That's what has never happened in the past. People have assumed, because it's an institution for the mentally retarded, that it can meet a wide range of needs. But the institutions never had to prove that for one person, John Jones, who needs 12 different needs, that that institution could meet those needs.

So it puts a burden back on whether or not the actual service needs and objectives that (59) need to be met for that individual can be met by wherever he is committed to.

Q. You don't see any other alternative for securing those benefits besides the hearing we have talked about?

A. Not where it would be impartial and not subject to administrative convenience types of decisions that social service agencies have to make, no.

Q. Now, I'd like to turn, in our final moments, to the regulations that were enacted in 1973 by the Pennsylvania Department of Public Welfare regarding the admission of juveniles under the 1966 Mental Health and Mental Retardation Act, Sections 402 and 403 of that act.

According to stipulation between the parties, these regulations are now used and applied only to the mentally retarded, not to the mentally ill.

For convenience, I would like to explain for the record that I am referring to the regulations as they are reprinted in Footnote 5 of the initial opinion of the District Court of July 24, 1975, as printed at 402 Fed. Supplement 1039, Footnote 5 on Pages 1042 and 1043.

Do you have those regulations in front of (60) you, Miss Glenn?

A. Yes, I do.

Q. Paragraph 1 provides that, "All juveniles aged 18 and younger to be admitted to an Institution must be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist."

Could you tell us, Miss Glenn, whether you note any deficiencies in that paragraph?

To save time, you could incorporate by reference some of your earlier testimony; but I'd appreciate your just telling us what you find, what deficiencies you find, in this provision?

A. I think I've covered the fact that individual pediatricians or physicians or psychologists or even groups thereof do not, historically, have the knowledge appropriate to make decisions like that, do not know the alternative for services available in the communities, and a provision like this is certainly subject to abuse.

One of the patterns of behavior for parents attempting to institutionalize their child has always (61) been a shopping behavior, to shop around until they could get the right words on the right page from whatever physician they could find or psychologist; not just parents, other

social agencies, social case workers, welfare workers. That's subject to abuse too readily.

Q. I take it your earlier comments on the problems depending on institutions and community facilities would also apply to this paragraph?

A. Yes.

Q. Paragraph 2 of these regulations states, "This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care. However, a medical or psychological evaluation may accompany a referral of a mentally retarded juvenile."

Could you comment on that provision, please?

A. Well, obviously, the reports by any of what we talked about in provision 1 of the individual pediatrician, psychologist, psychiatrist, are subject to the same errors of those individuals. That's certainly a limited documentation to make a life-long decision for a person, what a psychologist or a (62) psychiatrist says.

Q. Does this Paragraph 2 describe the required evaluation in a way which would assure it would contain the information necessary to decide whether a child needs institutionalization?

A. Not at all.

Q. Generally, what additional information would need to be required in order to consider those questions? What is lacking here?

A. Well, two major areas. One would be the specificity of the type of information on the person that would be required, of his needs, and what types of environments as well as training programs would be most appropriate to meet those needs, so certainly a specification of the type of clinical information on the individual.

On the other hand, information relative to whether or not the person could be kept in the home if another range of services were provided or how decisions are made about service delivery to meet those objectives for the individual in what the alternatives are to total institutionalization of a person.

Q. Paragraph 3 of the regulations states, "The Director (63) of the Institution or his delegate, shall have conducted an independent examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile."

Could you comment on whether this review by the institution of the proposed juvenile involves any deficiencies, in your opinion?

A. Well, I've already covered that I don't think the institution should make decisions; but certainly for a regulation covering commitment, any person that is involved in that decision should not be an after the fact type decision, which it sounds like this is. It sounds like a person would have to have been placed into that institution before that particular level of review has taken place or could even take place.

Q. I take it you are referring especially to the last four words, "shall discharge the juvenile."

A. Yes, that's what made me believe—

Q. Postadmission?

A. It would have to be postadmission, yes.

Q. Paragraph 4 of the regulations requires that the telephone number and address of the juvenile's parents (64) person who is requesting admission for the juvenile must accompany the referral. I don't think I have any question of you on that paragraph.

Perhaps Mr. Hoffman will. It seems to me the general requirement under the statute that the person who is seeking to admit the child disclose his or her identity.

Paragraph 5 of the regulation states, "Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission, and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached)."

For mentally retarded juveniles, could you explain any deficiencies you see in this paragraph?

A. This paragraph, on reading it, I would assume it was written for emotionally disturbed, rather than mentally retarded. Mentally retarded people (65) would not be able to read the written notification or understand the explanation of his rights or have ever had an opportunity to learn how to use the telephone or understand what counsel is, so it's inappropriate for this alone to be the type of notification or capability of the individual to receive counsel on his own understanding of that, being able to do that.

Q. For that minority of the retarded who might know how to use the telephone or might know what counsel is, could you describe whether or not that juvenile would be able to independently and freely exercise the choice that would be involved in stating an objection to the institution and calling or notifying counsel of the client's feelings?

A. Certainly some mentally retarded people would be able to. However, mentally retarded people that are in institutions are typically afraid to.

There is a certain atmosphere of pressure that goes along from staff and peers not to complain, not to go outside the standard rules of daily routine of the institution. I can see them being reluctant, even those that could do it, to actually carry through with these procedures.

(66) Q. So if a retarded person who was in this minority who was more articulate than most didn't object to being there, could I assume that that person was satisfied with the institutionalization?

A. Not at all, no.

Q. Paragraph 6 of the regulations is rather lengthy. I won't read the entire paragraph into the record.

It generally requires that, in the event a juvenile does object, the juvenile being 13 or older, to remaining in the institution, that the Director may continue the institutionalization for two days, during which time he notifies the applicant for the commitment and the referral unit so that either may institute a court commitment proceeding.

The Director of the facility also notifies potential legal services; and if a court commitment proceeding is begun, the juvenile remains institutionalized. I'd like you to first state whether or not you have read the entire text of the paragraph, since I haven't read it?

A. Yes, I have.

Q. Could you tell us any problems that you see with that paragraph, again incorporating any of your earlier testimony by reference?

(67) A. Well, the basic problem is it puts the burden on the retarded juvenile to initiate the process. Some

retarded persons are not going to understand it to initiate it.

Others, as I indicated, because of the social pressures within the institution, are going to be reluctant to initiate a process like that. It's putting an awful lot of burden on young retarded persons to stand up against a big institution, which is not a common behavior.

Q. I note that Paragraph 8 of the regulations says that if the patient is "incapable of understanding the notification, it shall be written on the notification."

Do you see anything in the regulations that would provide any substitute advocate for the person who doesn't understand the notification?

A. No, I don't.

Q. Does that present any problems for you in evaluating these regulations?

A. Especially when you're dealing with mentally retarded persons.

Q. Could you tell us what other general deficiencies you find with regard to these regulations, regarding (68) either the time of the hearing, the age restrictions involved, any other kinds of problems?

If you like, I can be more specific in my question; but if you can answer, I'd appreciate it.

A. One would be the one that the Court noted here, that there is no time, there is no time procedure set up where he can assure there is speedy decision making.

The other main deficiencies deal with the fact that there is no specificity with respect to the objectives set for the individuals, time frames on the objectives to be met by the institutions if the person is placed there. You still have an indefinite commitment here. If a person has only one problem—the person may have only had one

problem that caused the initiation of commitment procedures that could be corrected in one week, two weeks, or three weeks or some other time frame. But there is no responsibility within the regulations to enumerate the objectives for the individual, enumerate the time frames that the institution is to meet these objectives, such that there is review and the person has an opportunity to get out of the institution after the objectives are met that caused the commitment proceeding in the (69) first place.

Q. Giving the State of Pennsylvania the benefit of the doubt and assuming that a hearing would be held within a few weeks to a month of institutionalization or even, say, a week or a couple of days, are there harms that would likely result to either the mentally retarded juvenile or someone who is mistakenly thought to be mentally retarded from that short period of institutonalization before all these procedures can be given effect?

You may have answered that earlier.

A. I'm not sure I understand the question.

Q. Let me clarify it a little bit.

You described earlier in great detail the harms that can be caused by institutionalization. Assuming that the State of Pennsylvania does a better job than is called for in the regulations, or even assuming the regulations are followed, so within a few days or week or month a hearing is held—

A. After the person is institutionalized?

Q. After the person is institutionalized, are there harms during that interim period prior to the hearing that can befall an individual?

(70) A. Twofold, yes. Assuming, on my part, that the Pennsylvania institutional services that people would be committed to are typical of the rest of the United States, where they are understaffed, overcrowded, professionally isolated in most instances, the real problems of institutional abuse that goes on—there is a potential for even physical harm to the individual on a short-term basis, crowded wards, lack of staff, clients to have a tendency to harm themselves or each other because of lack of supervision and lack of other things to do besides stereotype behaviors or fighting in the institution—staff abuse is pretty common, too, in a contained environment, low paid individuals that are overworked, that have so much responsibility and so many children to watch, that they get frustrated, and there is abuse that goes on in the institution that is harder to monitor in an institution.

So, to the individual himself, there is certainly physical harm that could happen.

The other harm really is back to the emotional decision making process of the parents. Once that commitment has been made, I mean, it's like closing the door on the type of parental-child relationship (71) that existed in the past. There is much more resistance, even if a lot of alternatives are offered to the parents, either in the home or some other residential setting; to go through that emotional thing again, to then go through it to place the child somewhere else or to have the child come back home, even with the amount of services that would have initially prevented them from ever having to institutionalize the child.

So for a second step to be taken for this person for his hearing after he is in the institution is going to be a lot harder for the parents to accept.

Q. I would like your answer and your opinion on an issue that has frequently come up in my discussions with other people regarding this case.

You have said that you would support a hearing and counsel and procedural protections for the child proposed for commitment to an institution for the retarded.

Suppose a family seeks such a hearing, a hearing is held, the family explains their reasons for wanting the child to be institutionalized, the (72) stress and crisis of the family is all laid before the impartial tribunal deciding the question, and the decision is, because of either the alternatives available or the facts of the particular case, that the child should not go to the institution, but should remain uncommitted, should not be placed in the institution.

Wouldn't it be worse for the child to have to return to this family that has just asked a tribunal to commit the child?

Do you have any thoughts on that?

A. I don't know what you mean by worse for the family, I have not—

Q. A lot of people seem to feel that the decision—maybe I'm asking you whether you feel this way—the decision at the commitment hearing is simply do we commit the child or not; and then, if the decision is not, then the child goes back to the same distressing situation, possibly the home that the child came from.

A. Well, through the hearing process itself, a lot of things are going to be cleared up that may have been—well, the fact finding, the conflict that may arise, those would be cleared up, so many (73) of the problems may have been resolved.

The exploration of alternatives would give the parents, as well as any social agency involved, other resources to apply to that family with that child or for that

child out of the family that would not have been exhausted if the child had been institutionalized.

So, yes, there may be an impact. But I think it would be a lot less injurious to the person than to have that person institutionalized because they would have knowledge now of the facts and any other resources and social agencies to get appropriate services for the person.

Q. And you just said "they."

Do you mean the family as well as the retarded individual?

A. Yes.

Q. Here in Massachusetts, for your state facilities, do parents or guardians apply for, and do the institutions accept admissions of mentally retarded juveniles?

A. Because of the problems inherent in institutions as not being appropriate for people, we have closed admissions to institutions in Massachusetts.

Q. So what we have been talking about from the point of (74) the Pennsylvania case doesn't happen here in Massachusetts?

A. It is very rare that we cannot develop an alternative for a person or provide services in a home; and in those rare instances, like the whole family dies except for the kid and he has no place to sleep for that night, there is a time problem as well as a service problem, an admission could be made, but only short term until, you know, a program is developed.

Q. How long, typically, would that short-term emergency—

A. It varies so greatly. We would definitely try to keep it under 30 days. But that is rare.

Q. How long have admissions been closed to Massachuetts institutions?

A. Approximately two years.

Q. And—

A. Before I got here, they closed admissions to children, and I don't know what year. I don't know the age —I think it was six and below, young children.

After I got here, we closed it to everybody.

Q. And I take it that you have not had any catastrophe or crisis arise in the care of mentally retarded juveniles in Massachusetts by the unavailability (75) of those institutions?

A. No.

MR. FERLEGER: I have no further questions. Thank you very much.

Mr. Hoffman may have one or two.

THE WITNESS: Can I make a phone call?

(Recess.)

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(76) *Cross-Examination*

BY MR. HOFFMAN:

Q. Could you describe for us your experience in evaluating facilities in Pennsylvania?

A. Yes. I was put on contract by the Department of Welfare in Pennsylvania in, I believe, 1972 to run three training programs for staff and citizens and program providers in Pennsylvania to learn to use the program—to use the PASS system, Program Analysis of Service Systems. That is an evaluation system.

Each of the three workshops I held, one in Harrisburg, one in Pittsburgh, one in Philadelphia, between '72 and '73, I believe—it may have been part of '74—the

workshop is held where one or two days is more ideology and theory and how to use the instrument, and the last two or three days is always evaluating a whole range of different services so they learn how to utilize the evaluation instrument itself.

So I not only participated on the teams that evaluated services at those three workshops, but supervised the evaluation of all of the review teams that were being trained. There may have been (77) at any one time five or six different teams that were going out to evaluate two to four different services in those areas. So I supervised and participated in the evaluation of approximately 15 or 16 different services in and around the areas. Well, we spread out quite a bit around the areas, but around Harrisburg, Philadelphia, and Pittsburgh.

Last year I was asked by the Justice Department to evaluate some of the community programs in the three-county area that served Pennhurst, or Pennhurst serviced people from those three counties. So we evaluated a range of community programs, but some day programs, in that area.

MR. FERLEGER: Excuse me. For clarification, could you tell us which Justice Department, whether it was five counties or three counties—I'm not sure whether you were saying it was three counties you were in or whether the lawsuit involved—

THE WITNESS: No, three counties I was in.

Q. Were you conducting that survey for the Pennsylvania Justice Department or the United States Justice Department?

(78) A. United States Justice Department.

Q. You stated in your direct testimony that you felt there were good community programs in Pennsylvania?

A. Yes.

Q. Would you please expand upon that, briefly?

A. The programs that I evaluated in Pennsylvania, when I compare those to community programs across the country, I would put them above average in quality. They have been developed on the basis of some very solid principles of normalization, developmental growth, individualization. They know the importance of the location of the facilities, the integration of the persons, the types of activities the persons learn to do, so I would put them above average, certainly above average in quality, of the community programs that I have evaluated.

Q. You are referring here to what I think we would call community living arrangements?

A. Yes.

Q. Are you familiar with Pennsylvania Family Resource Services Programs?

A. What?

Q. Do you have an opinion as to the quality of that (79) program?

A. I'm not sure I know enough about it to speak to that. I believe some of the services that we evaluated during the workshops—No, I better not speak to that. They were just developing Family Resource Services as a unit within the Department of Mental Retardation under the welfare office when I first started doing workshops, so—

Q. And you started doing the workshops in 1972 or 1973, is that correct?

A. I believe so. They hired a staff member away from me when I was in Omaha to go head up the newly-budding division of Family Resource Services.

Q. So you wouldn't know what the status or funding of the Family Resource Services Program would be at this date?

A. Not unless, unknown to me, some of these services I evaluated last year were funded by them or partially supported by them. I don't know.

Q. For clarity of the record, I think I should define what I've been talking about. If you would like to do that instead of me, describe the services in the Family Resource Services Program as you know it in Pennsylvania.

(80) MR. FERLEGER: I think she said she doesn't know it well enough.

MR. HOFFMAN: I believe—

Q. Will you describe for us generally the purposes of the Family Resource Services Program in Pennsylvania?

MR. FERLEGER: If you know.

A. I don't know currently, today. I knew back when they were starting, what they were starting it for. I don't think I can speak on it today as the range of services under that particular component of mental retardation services.

Q. Are you familiar with the admissions process by which juveniles would be admitted to institutions in Pennsylvania as you have defined them?

MR. FERLEGER: Are you referring to the statutes involved that are, I think, Paragraphs 2, 3,

or 4 of the Court's opinion, or are you referring to the regulations or are you referring to something else?

MR. HOFFMAN: I'm asking Miss Glenn her understanding of the admissions process in Pennsylvania and then we will explore it from there.

THE WITNESS: The only thing I'm familiar with is the one I responded to. That was the one—Footnote 5 of the order.

(81) Q. Do you know how many applications for admission of juveniles to institutions are received annually in Pennsylvania?

A. No, I don't.

Q. Would you have any estimate of what percentage of those admissions—at this point, I think I'd be referring to public institutions—are accepted for admission?

A. No, I have no idea.

Q. Do you know whether Pennsylvania public institutions accept the referrals directly from parents?

A. No, I do not.

Q. Would it change your opinion in any way that you have expressed in your direct examination if I told you that referrals were not accepted at most public institutions directly from parents?

MR. FERLEGER: Are you speaking, Mr. Hoffman, of juveniles or adults?

MR. HOFFMAN: I'm speaking regarding juveniles in all cases, since that's what the focus of this lawsuit is.

MR. FERLEGER: You're also speaking of mentally retarded juveniles?

MR. HOFFMAN: That's correct.

(82) MR. FERLEGER: But the regulations say that there has to be a referral, that it can't be by the parents, so I don't understand the question. How could that change her opinion if the regulations say that the parents don't do it directly, but it has to be through a referral?

Maybe I misunderstood.

MR. HOFFMAN: Maybe you did.

Q. Do you know whether the institutions have—what processes the public institutions have for considering the appropriateness of an application of a juvenile mentally retarded person to that institution?

A. In Pennsylvania?

Q. Yes.

A. No.

Q. Do you know whether they require the referring agency, psychologist, or other referring entity, to have explored alternative community placements?

MR. FERLEGER: Objection. Procedures are listed in regulations, which don't require exploration of alternatives. If there is any such requirement, it hasn't been brought to the attention of the Court in this case.

Q. Would you please respond to the question?

(83) A. The only thing I'm aware of is this set of regulations we dealt with today.

MR. FERLEGER: If there are any other regulations, Mr. Hoffman, maybe you should unveil them now so we can see what the secret rules are.

MR. HOFFMAN: I don't think I stated there are any additional regulations.

Q. I think you stated that—if I'm incorrect, please correct me—that one of the problems in identification of persons who may be mentally retarded is over reliance or exclusive reliance upon IQ tests at the expense of considerations of adaptive behavior and problems in adaptive behavior and whether those problems arose during the developmental stage, is that correct?

A. That's one problem.

Q. Do you know what the definition, statutory definition, of mental retardation is in Pennsylvania?

A. No.

Q. Would it change your opinion with that problem if I told you that the definition in Pennsylvania includes those three factors?

A. No, because that's common in many states. But still there is reliance on IQ's. People don't go back (84) to the regulations for day-to-day decisions.

Q. Would your opinion about the inherent conflict of interest in the institutional staff making the admission decisions be changed in any way if I told you that an overwhelming percentage of applications for admission were rejected by the institutions?

A. No.

Q. Why not?

A. Because there are too many other factors that come into play. The rejection of a percentage or a large percentage or a substantial percentage does not mean

that, for political reasons or any other reasons, they would not accept any one individual, and that would be inappropriate for that one individual. There is no check and balance on the system right now if the institution is the decision maker.

Q. So because in what might be isolated instances, there may be what you would consider to be an inappropriate decision by an institution that a person should be placed in that institution, you would still feel there is an across-the-board bias of institutional personnel in making those decisions?

MR. FERLEGER: Objection. You are following (85) up a question that included an assumption that just because a large proportion of applications might be rejected, that those that are accepted somehow are made more valid. It's like if you have 100 applications and you only accept five, the fact that you rejected 95 doesn't mean that the five should have been accepted.

MR. HOFFMAN: Miss Glenn stated in her direct examination that the institutional staff could not be trusted to make a decision because of what I took her to be saying was an inherent bias on their part. I am asking her whether, if the facts do not demonstrate that across the board, whether she still holds that opinion.

MR. FERLEGER: She already told you the facts do not demonstrate that. You mean across the board in every admission?

MR. HOFFMAN: Yes.

MR. FERLEGER: Bias can still be there even if you say I don't want this person to come into

the institution. You can still incline toward accepting the person even if your ultimate decision is to reject the person.

MR. HOFFMAN: I'm trying to explore whether (86) Miss Glenn would offer her opinion if facts do not support that on an across-the-board basis.

MR. FERLEGER: All right, objection.

THE WITNESS: The fact that a period of time where a certain individual superintendent or staff member did not accept people into an institution doesn't set out any standardized procedure to be sure that doesn't happen for any one individual at any other time. It's still personality based and subject to any number of decision-making reasons that have no relationship to the needs of a person that is being considered for that institution, so it would not change my opinion.

Q. I'm somewhat flattered, I must say, that in discussing who is the appropriate person to make decisions about the appropriate placement for mentally retarded individuals, that you have found courts and lawyers to be that person.

Have you found courts to be particularly well informed about mental retardation?

MR. FERLEGER: Objection. That misstates her testimony. Miss Glenn suggested a process for decision making, rather than any particular individuals (87) for appropriateness of that test, and I object further on the basis that the courts deal with the most technical problems in every area of life. They deal with who worked out the first concepts

for making some industrial machinery and copyright cases. They deal with autistic law, they deal with the most complicated aspects of manufacturing in liability suits.

So whether or not a particular judge or judges generally know a lot about retardation has nothing to do with this case.

Q. In the hearing model that you described, you provided that a judge would make the final decision regarding whether a placement was appropriate and what that placement would be, is that correct?

A. A judge or judges or—I said a judicial process, and I have found, to answer your previous question, that on individual cases, and I appear in court a lot on individual cases, that the impartial review of the judge in that system—the Court does several very important things. It focuses the attention of everybody on the individual and his rights, and I have found that process to work very well to ensure that the results of those proceedings are fair and (88) accurate and the rights of the individual are foremost in the decision process.

I have not found that when professionals are involved because of built-in biases and ideologies of what should happen to people.

Q. Have you found the judges are well informed about mental retardation itself?

A. I've never discussed really with the judges that have heard cases their knowledge of the medical or social aspects of retardation. I couldn't answer that.

They deal with the facts of the case and the presentation of witnesses and the lawyers. I've never gotten into that with them.

Q. Have you found that judges are well informed about community alternatives for placement of mentally retarded persons?

A. I don't think they have to be, but I have as of late, yes.

Q. Have you found that defense attorneys or attorneys assigned to represent a person alleged to be mentally retarded are informed about mental retardation?

A. Oh, yeah, as of lately with all the advocate groups and the appointment of lawyers with specialties of (89) areas like mental retardation, they know a lot more than people involved in social services lately.

Q. Is it your opinion—excuse me, strike that.

Were you an expert witness for the plaintiff in the case of Halderman versus Pennhurst?

A. I think they were plaintiff intervenors, the United States Justice Department.

Q. Is it your opinion that an institution as you have described it is never, except in the rarest of circumstances, an appropriate placement for a mentally retarded individual?

A. Yes.

Q. Is it your feeling that the present—

A. Let me back up. The definition I gave you of an institution, if you get to a very small, specialized facility, under my definition may meet the definition of an institution; but it's very small, 10 people, five people, very specialized, for a short period of time for a very specific purpose, like a medical stabilization need of an individual that would take two months or so. Then that's appropriate.

Q. I understand that. Is it your opinion that the present processes for admission of juveniles are defective

in large part because they result in placement in institutions?

(90) MR. FERLEGER: Objection. Miss Glenn was asked her opinions about what ought to be the case. She was not, as I recall, asked her opinion about the general present processes, except perhaps for the regulations.

Q. Please answer the question.

A. Could you restate it?

(Question read back.)

THE WITNESS: Partially. The decision-making process for placement into any program is defective in social service agencies; but, yes, commitment proceedings, because they have only looked at instiitions, are defective because of that. That's all they have looked at in most cases.

Q. Do you consider yourself capable of deciding what would be an appropriate placement for a mentally retarded individual?

I'm assuming here that you have had the opportunity to examine the juvenile, to meet with his or her parents, that you have knowledge of the community services, either residential or otherwise, that would be available.

MR. FERLEGER: Mr. Hoffman, are you also assuming that she has resolved the factual conflicts (91) and all those other considerations—

MR. HOFFMAN: I'm assuming she is possessed with all information that she would deem necessary to know about a mentally retarded child prior to making a decision about whether some placement was necessary or not.

THE WITNESS: I am capable, professionally, to make a decision about the type of service needs a person has, yes. I do not personally possess the skills to resolve factual problems, resolve conflict.

I don't know if that answers your question. I can evaluate a mentally retarded child, and if it has been deemed—I don't think I possess, alone, the capability of saying a person should be taken out of their own family. I could say clinically, with the family and with the child, what services that child would need, whether in the home, whether somewhere else, what type of environment, what type of objectives should be checked, how that should be done from a clinical standpoint.

I can take a child in an institution and say what type, if he could not go back into his home for any reason, what type of community residential program, what type of community day training, what type of ancillary services that (92) would best meet the objectives of the child. I could not, as a professional, make a decision about taking a child out of a home, however, no.

Q. I'm not sure I understand the distinction you are trying to make.

You could not make a decision to take a child out of a home. Why not?

MR. FERLEGER: It's not her job.

Q. I think my question is whether, if parents of a mentally retarded child approached you as a professional and explained to you a family history and permitted you to examine that child and to become informed about the

family history, if you could make an appropriate decision as to what types of services were necessary for that child?

A. It would be a very rare instance that the first decision should not be what types of services were necessary to keep that child in their own home. On instances of should the child be taken out of the home, that's more of a welfare abuse, neglect type of decision that I am not professionally prepared nor capable of making.

Q. When we are talking about taking the child out (93) of the home, my question is not limited to taking the child out of the home and placing him or her in an institution that you think is undesirable.

It also includes placing a child in a setting that you think is conducive to his development. Does that alter your answer in any way?

A. I was thinking of that when I answered, so, no, it doesn't.

MR. FERLEGER: I want to object to any further questioning along this line because I think that Miss Glenn's hesitations and her obvious concentration in trying to answer this question are due to the fact that the questions are objectionable because they ask Miss Glenn, a mental retardation professional, to give us the ultimate answer to the legal and social questions that are before the Court.

I would also like the record to reflect my objection that the same questions have been repeated a number of times, and Mr. Hoffman has obviously not gotten the answer he wanted; but he got the answer. I think we should move on to something else.

(94) MR. HOFFMAN: The reason we are pursuing this line of questioning is that Miss Glenn testified a Court should make that decision, and I am trying to find out why Miss Glenn feels a professional such as herself is not as capable or more capable of making that decision.

MR. FERLEGER: My objection remains because this litigation is to determine whether a decision to deprive somebody of liberty is a decision that requires the traditional due process that our society requires for those decisions.

I have never heard it argued, for example, that a penologist who knows all about criminal behavior should be the one to decide whether a criminal is convicted or sentenced to prison for a crime.

In the same way, a mental retardation professional has no qualifications to decide whether someone should be deprived of liberty because they are retarded.

MR. HOFFMAN: I think the inappropriateness of your analogy is fairly apparent.

Q. You stated earlier—

MR. FERLEGER: It's in the eye of the beholder.

(95) MR. HOFFMAN: Thank you, Mr. Ferleger.

Q. You stated earlier that admissions of juveniles to institutions in Masschusetts have been closed.

Is that only to public institutions?

A. They have been closed—public institutions, yes, but it's not just juveniles. They have been closed to everybody.

Q. So do I presume that admissions of juveniles, mentally retarded persons, are continuing to be made to private facilities in Massachusetts?

A. Not through the Department of Mental Health.

Q. But they are continuing to be made outside the auspices of the Department of Mental Health?

A. Yes.

Q. In your opinion, are the hearings, judicial processes you have described necessary before a child could be placed in a community living arrangement?

MR. FERLEGER: Objection. She testified that institutions, because of the harm and the stigma and deprivation of liberty, require those kinds of procedures.

When somebody is living in a community, this lawsuit doesn't ask that any procedures be (96) adopted. So in addition to your having misstated her testimony, I object because the question and the answer, of course, are not relevant to the complaint in this case.

MR. HOFFMAN: We may disagree about the scope of the lawsuit, and I know that Miss Glenn stated that a hearing should precede an institutional placement. I'm not at all certain that she stated the converse of that, and I'd like to ask her that at this point, whether a hearing is required before a child would be placed in a community center.

MR. FERLEGER: Objection.

THE WITNESS: With my definition of community services?

Q. Yes, utilizing your definitions.

A. As stated in the earlier testimony, I would say no. But that is strictly with that definition. There are so-called community programs that deprive people of rights.

Q. But utilizing your definition, would you feel that parents, together with either social service personnel or mental retardation professionals, are sufficient to make that decision?

A. Yes.

(97) Q. I believe you mentioned somewhere in your direct testimony a respite care program?

A. Yes.

Q. Could you describe that for us briefly?

A. Respite care is a catchall term for a number of different types of services that can be provided for short-term assistance to the family in the way of babysitting services so the family can take a short vacation, to go out for the evening when they don't have a babysitter trained to take care of a multiply involved child, an out of home temporary short term, one day, two days, one week, so that the family can be relieved of some of the ongoing, 24-hours a day, 365 days a year burden and stress placed on the family sometimes because of the extraordinary needs of the child.

So respite care is for the purposes of family rather than training or treatment for the child.

Q. Does that program have as one of its goals to relieve tension on a family and thereby encourage families to keep mentally retarded individuals within the household?

A. Yes.

(98) Q. Does interim care ever involve a residential placement out of the home?

A. You are talking interim like I am—

Q. Excuse me. Respite care?

A. Yes, it does.

Q. Do you believe a judicial hearing as you have described it is necessary before that type of placement is made?

A. Not if it's short term and not to a facility that's going to deprive the person of rights and endanger her potentially.

Q. Are you saying that you do believe that a hearing, a judicial hearing, is necessary before respite care would be provided in an institution—

A. Institution, yes.

Q. —as you have defined it?

A. Yes.

MR. FERLEGER: I'd like to move to strike the testimony regarding respite care. There is nothing in the complaint regarding that matter, no facts that I know of before the Court except a couple of footnotes maybe in some brief of Mr. Hoffman's co-counsel on that issue.

I think it's not relevant. The standard (99) called for by the Court requires a hearing if the person is held longer than three days, so that if the person is institutionalized for longer than the three days, the hearing would be required. You are just calling it by a different name. I don't think there is any relevance.

MR. HOFFMAN: I think it's apparent from Mr. Ferleger's comments, and I agree with his char-

acterization of the Court's opinion, that the Court's opinion would require hearings prior to a respite care placement.

MR. FERLEGER: In an institution. We don't have anything in the record regarding any problems that occur or have occurred or even what the respite care program is.

MR. HOFFMAN: Except that the statutory basis for the respite care program would be the very statutory admission procedures that we are discussing in this lawsuit.

MR. FERLEGER: Not so far as I know or anything in the record indicates.

MR. HOFFMAN: Again, we have disagreements about the scope of the lawsuit.

MR. FERLEGER: I read the statute a number (100) of times since 1972 and so did a number of judges, and I haven't seen any indication in any of my readings or their readings that the statute talks about respite care. I don't see those words or any reference to that concept in the statutes or in the regulations that your department adopted.

Q. (By Mr. Hoffman) Do you believe that a hearing, as you have described it, is necessary before a child would be hospitalized for medical care?

A. No.

Q. Why not?

A. Hospitalized for medical care, I assume, means into an accredited hospital that is providing acute medical services on a short-term basis.

Q. I'm not certain we can make any of those assumptions. I'm not certain we can assume that a parent is placing a child into an accredited hospital, and I don't know that we can assume that the placement is short term.

MR. FERLEGER: I object. Your question becomes so vague that it's meaningless.

THE WITNESS: I don't think that I can answer.

Q. Do you believe that a hearing would be required (101) before a parent can place a child in a medical facility for a long-term course of medical therapy, possibly chemotherapy, or, as another example, a procedure such as amputation followed by inpatient rehabilitation?

A. No.

Q. Why not?

A. Because there are enough procedures and precautions taken by the medical profession and the periodic review required—that is put on hospitals about the appropriateness of placement on an ongoing basis that those procedures are taken into account. There is enough pressure because of the fiscal costs within hospitals from the insurance companies, if they are picking it up, or the date, if they are to pick it up, to make sure that that person doesn't stay there any longer than necessary for that medical treatment. There is enough built-in precautions.

Q. In other words, you feel that nonjudicial mechanisms are sufficient to insure the appropriateness of that placement?

MR. FERLEGER: I think her testimony can stand on its own two feet without your interpreta-

tions. (102) If Miss Glenn has anything to add, then she should add it; but if she doesn't she need not.

THE WITNESS: There are so many—when you say nonjudicial, there are so many other things that affect appropriateness of placement or inappropriateness of placement in a hospital that I wouldn't want you saying nonjudicial to me and automatically say just an administrative procedure. That's not what controls hospitals, just an administrative procedure.

Q. I think you stated in your previous testimony that institutional staffs were generally ignorant of community alternatives, is that a correct statement of your testimony?

A. Of the total range of community alternatives, certainly.

Q. Do you have any reason to believe that's true of institutions in Pennsylvania?

A. Only that my understanding of institutions in Pennsylvania is that they are very typical of institutions across the country.

MR. FERLEGER: As a matter of fact, Bob, your own client's defense of the Pennhurst case rested on that very assumption, that Pennhurst and (103) Pennsylvania institutions were typical of those across the United States.

MR. HOFFMAN: I'm merely asking whether Miss Glenn has any reason to know specifically that the staffs in Pennsylvania institutions are ignorant of community alternatives, which is the statement that I think is contrary to fact.

THE WITNESS: I'll answer this way: I do know the structure of where institutions fit into and

do not fit into the entire availability of services in the Commonwealth of Pennsylvania. The base service unit structure. There would be a tendency, just from administrative separateness of the institution's actual operation from the community services as run through the counties and state funded community living arrangement programs through the base service units, there would be a tendency for them to know less about community programs in Pennsylvania than there would in Massachusetts, where there is a strong attempt to tie in the area office responsibility, which would also be similar to the base service unit responsibility, with the institutions. So there would be more of a tendency not to know in Pennsylvania than some (104) other states because of the administrative way they are structured.

Q. How would you safeguard that—strike that.

(Discussion off the record.)

MR. HOFFMAN: I have no more questions.

MR. FERLEGER: I have just one thing.

Redirect Examination

BY MR. FERLEGER:

Q. Commissioner Glenn, I appreciate your patience for these last three hours plus that we've been here.

Mr. Hoffman asked you about whether a hearing would be needed before a child was placed in a medical facility for some long-term medical care. I believe he used amputation as an example. You gave some reasons. I know that but for an opportunity to clarify those reasons,

Mr. Hoffman might cite in a brief or some reference just that part of your testimony rather than earlier parts of your testimony which referred to the same issues, so I'd like to know whether you see, in terms of medical care versus mental institutionalization distinction, any relevance (105) of the stigma involved, the institutional risks and dangers involved, and the life-long effect involved in the mental institutionalization situation?

A. Very definitely. A regular hospitalization is a valued part of a community. Thus, the stigma would not be attached to a person having been placed there for whatever acute problem that person had. There is certainly less likelihood for the institutional abuses to take place because of the protections of the operation of hospitals and the type of staffing patterns, the type of funding mechanisms that they have.

What was your third one?

Q. The life-long effect and the deprivation of liberty and the exposure to institutional dangers and risks.

A. The reasons for hospitalization are almost invariably short term. Otherwise, like if it was to go to a nursing home for a long period of time, yes, I'd say there should be a hearing. A nursing home is an institution also, but the short-term nature and the very objective oriented to solve the medical problem and get the person out avoids the risk of the long-term problems created by separation of that person from the community (106) environment and the experiences that I was talking about earlier.

Q. In terms of the social functioning of the medical hospital, does that differ in terms of its openness or its closedness from the mental hospital, mental institution?

A. If I understand what you mean, there is no incentive in a hospital setting for retaining a person there longer than necessary or for the overprotectiveness to develop concerning the client's activities or liberties or capabilities or restrictions on visitations or—if that's what you meant.

Q. In order for your earlier answer to Mr. Hoffman on this issue to be correct and complete, if, for example, he wanted to refer to it in a brief, would we have to include your answers to my questions on this redirect examination?

A. To be complete, yes.

MR. FERLEGER: No further questions. Thank you.

(Whereupon deposition was concluded.)

(107) CERTIFICATE

I, Cindy Marie Hansen, a Notary Public duly commissioned and qualified in and for the Commonwealth of Massachusetts, do hereby certify that there came before me on the 7th day of April, 1978, the person hereinbefore named, who was by me duly sworn to testify to the truth of his knowledge concerning the matters in controversy in this cause; that he was thereupon carefully examined upon his oath and his examination reduced to typewriting under my direction; and that the deposition is a true and accurate record of the testimony given by the witness.

I further certify that I am not interested in the event of the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 10th day of April, 1978.

Cindy Marie Hansen

My Commission expires Feb. 25, 1983.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S.; by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated

v.

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated

OPINION AND ORDER

Before Honorable John J. Gibbons, Circuit Judge and Honorable Daniel H. Huyett, 3rd and Honorable Raymond J. Broderick, District Judges

HUYETT, J., May 25, 1978:

I. *Introduction*

In 1975, this Court, convened as a three-judge federal court pursuant to 28 U.S.C. §2281[1] held that certain provisions of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (1966 Act) providing for voluntary commitment and admission to mental health facilities were unconstitutional.[2] *Bartley v. Kremens,* 402 F.Supp. 1039 (E.D. Pa. 1975), *vacated and remanded* 431 U.S. 119 (1977). We concluded that these provisions failed to provide juveniles committed to mental health facilities with specific procedural rights guaranteed by the Fourteenth Amendment to the Constitution which could not be waived by parents, guardians, or persons standing *in loco parentis.*

[1] 28 U.S.C. §2281 (1970) provided that an application for an injunction against the enforcement of a state statute on grounds of unconstitutionality must be heard by a three-judge district court. This provision was repealed on August 12, 1976.

[2] Sections 402 and 403 of the 1966 Act provide in part:

Section 402. Voluntary admission; application, examination and acceptance; duration of admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of Section 402(a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

Section 403. Voluntary commitment; application, examination and acceptance; duration of commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

The Supreme Court vacated and remanded this case for further consideration in view of the passage by the Pennsylvania Legislature of the Mental Health Procedures Act of 1976 (1976 Act). 50 P.S. §§7101-7503 (Supp. 1977-78). The passage of the 1976 Act mooted the claims of the named plaintiffs[3] and, in addition, created distinctions, at least with respect to the governing statutory enactments, between mentally retarded and mentally ill juve-

[3] Under the 1976 Act, juveniles age fourteen and older are given essentially the same rights as are given to adults. The named plaintiffs in the original suit were all age fourteen or older; thus, they no longer had a live claim following the passage of the 1976 Act. *See Kremens vs. Bartley,* 431 U.S. 119, 126-27 (1977).

niles. It was the Supreme Court's opinion that, in view of these new statutory distinctions, the class action originally approved no longer met the requirements of Fed.R.Civ.P. 23(a). The Supreme Court therefore remanded "for consideration of the class definition, exclusion of those whose claims are moot, and substitution of class representatives with live claims." 431 U.S. at 135.

II. *Statutory Scheme*

We first consider the contours of the statutory scheme governing voluntary admissions and commitments of juveniles. A description of the statutory scheme is important in order to structure properly the subclasses to be maintained pursuant to Rule 23. Furthermore, a full understanding of the statutes is necessary to our determination of whether they satisfy the requirements of procedural due process.

A. *The Mental Health Procedures Act of 1976 (1976 Act)*

The 1976 Act repeals the provisions of the 1966 Act except as they relate to mentally retarded persons. Article II of the 1976 Act articulates the procedures for voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" that mandates full or parttime residence in a mental health facility.[4] Section 201 provides that "a parent, guardian, or person standing in loco parentis to a child less than 14 years of age" may apply for voluntary examination and treatment, and by so doing shall be deemed to act on behalf of the child.[5] Once a juvenile is accepted for voluntary examination and treatment, the 1976 Act requires that "an individualized treatment plan [be] formulated by a treatment team" within seventy-two hours[6]. The treatment plan must state whether inpatient

[4] Section 103 of the 1976 Act provides as follows:

> This act establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" shall include all treatment that requires full or part-time residence in a facility. For the purpose of this act, a "facility" means any mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, whether as outpatients or inpatients.

50 P.S. §7103 (Supp. 1977-78).

[5] Section 201 of the Act provides as follows:

> Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. *A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child.* Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

50 P.S. §7201 (Supp. 1977-78) (emphasis added).

[6] Section 205 of the Act provides as follows:

> Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment plan shall be formulated by a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

50 P.S. §7205 (Supp. 1977-78).

treatment is necessary and, if so, the reasons for that conclusion.

Section 206 of the 1976 Act sets forth the procedures for withdrawal from voluntary inpatient treatment.[7]

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[7] Section 206 of the Act provides as follows:

(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203, he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may affect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or his designate.

50 P.S. §7206 (Supp. 1977-78).

Where the person committed is under the age of fourteen, his parent, legal guardian or person standing *in loco parentis* may obtain his release. In addition, "any responsible party" who believes that it would be in the best interests of the juvenile to be withdrawn from inpatient treatment may petition the Juvenile Division of the court of common pleas of the county in which the juvenile resides and request withdrawal or modification of treatment. Then the court must appoint counsel for the child and schedule a hearing within ten days to determine "what inpatient treatment, if any, is in the minor's best interest." 50 P.S. §7206 (b).

B. *Mental Health and Mental Retardation Act of 1966 (1966 Act)*

The 1966 Act was the focus of the original *Bartley* decision in which this Court declared sections 402 and 403 of that Act to be unconstitutional.[8] Following the passage of the 1976 Act, only mentally retarded juveniles remain within the ambit of the 1966 Act. Sections 402 and 403 provide, in brief, that mentally retarded juveniles age eighteen or younger may be admitted or committed[9] to a mental health facility upon the application of a parent, guardian, or person standing *in loco parentis*, and may withdraw only with the consent of the admitting party or his successor.

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[8] For the text of sections 402 and 403 of the 1966 Act, *see* note 2 *supra*.

[9] As the Supreme Court noted, 431 U.S. at 124 n. 4, neither party has read the statute as containing a distinction between juveniles who are *admitted* voluntarily under section 402 and those who are *committed* voluntarily under section 403.

C. *1973 Regulations*

The 1973 Regulations,[10] promulgated by the Secretary of Public Welfare under the provisions of the 1966 Act,

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[10] The 1973 regulations provide in part:

1. All juveniles aged 18 and younger to be admitted to an Institution must be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist;

2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;

3. The Director of the Institution or his delegate, shall have conducted an independent examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile;

4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;

5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached);

6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, if he feels it is

augment the procedural rights given to mentally retarded juveniles by the 1966 Act.[11] Portions of the regulations apply to all juveniles aged eighteen and younger, such as the requirement that juveniles admitted to a mental health institution be referred by a mental health professional, pediatrician, general physician, or psychologist; that this referral include a psychiatric, medical or psychological evaluation stating specifically the reasons why the juvenile re-

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necessary for the youth to remain, may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director, or his delegate, shall notify the Public Defender's office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two-day period, the juvenile shall remain institutionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director, or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service Unit to file a 406 proceeding within two days after failure to locate the applicant;

7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile;

8. If the staff member of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification.

[11] The parties have stipulated that the 1973 Regulations presently apply only to juveniles committed as mentally retarded under the 1966 Act. Supplementary Exhibit No. 13, Stipulation No. 38.

quires institutional care;[12] and that the Director of the Institution conduct an independent examination of the juvenile prior to admission.

Additional rights are available to mentally retarded juveniles thirteen years of age or older. These juveniles receive written notification explaining their rights and furnishing them with the number of counsel whom they may call for representation. If a juvenile age thirteen or older objects to remaining at the institution, a commitment hearing must be held pursuant to the procedures provided for involuntary commitment.[13] We note here, as we did in the original *Bartley* opinion, that the regulations designate no time by which a post-commitment hearing must be held. 402 F.Supp. at n. 5.

In sum, there are two completely distinct statutory schemes which are under attack in this lawsuit; one relating to the mentally retarded (1966 Act as modified by the 1973 Regulations) and one relating to the mentally ill (1976 Act). Furthermore, with respect to mentally retarded juveniles, older juveniles are given some rights not accorded the younger juveniles.

III. *Named Plaintiffs*

There are twelve named plaintiffs in this lawsuit. Nine are mentally ill juveniles, age thirteen or younger, who were committed to mental health institutions pur-

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[12] *But see* note 55 *supra*.

[13] The procedures for emergency commitment and civil court commitment of mentally retarded juveniles are contained in sections 405 and 406 of the 1966 Act. 50 P.S. §§1405 and 4406. These sections are not challenged in this lawsuit.

suant to the 1976 Act.[14] The remaining named plaintiffs are mentally retarded juveniles, age fourteen or older, institutionalized under the 1966 Act and the 1973 Regulations.[15]

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[14] Four of the mentally ill juveniles have been discharged from Haverford State Hospital since the filing of the amended complaint. At the hearing held March 31, 1978, counsel for the Commonwealth moved for the dismissal of the claims of these plaintiffs on mootness grounds. However, we believe that these claims are not moot. *See Souder v. McGuire*, 423 F.Supp. 830 (M.D. Pa. 1976); *Meisel v. Kremens*, 405 F.Supp. 1253, n. 2 (E.D. Pa. 1975). These plaintiffs retain an interest in receiving declaratory relief, since the possibility remains that they could at any time be recommitted to a mental health facility under the challenged statutes.

[15] The named plaintiffs' medical records were offered into evidence at the hearing. Each plaintiff's records are divided into two portions: Part A consists of pre-admission background information, and Part B contains records from and including the actual admission note through the first staff conference. There was no objection to Part B, and those portions of each child's records were admitted into evidence. However, Part A was objected to by the plaintiffs on relevance grounds. Since there was no showing that these records were in the hands of the admitting officials and used by them at the time of the admissions, plaintiffs objected to the relevance of using these records to demonstrate that the defendant institutions engaged in a complete evaluative process prior to the decision to admit. We took the issue of the admissibility of these records under advisement.

Defendants subsequently submitted with their Supplemental Brief affidavits confirming the fact that virtually all of the information was received by the admitting facilities prior to admission. However, there still is little evidence showing in what way, if at all, these records were used during the admissions process. Plaintiffs have suggested that the material be admitted for the limited purpose of providing information on the social and family backgrounds of the named plaintiffs. After examining these rec-

Plaintiff Kevin S., age twelve, was admitted to Haverford State Hospital (Haverford) on July 18, 1977, pursuant to section 201 of the 1976 Act. Kevin's medical records reveal that his mother, who is separated from his father, has a history of serious mental illness, including incidents of hospitalization. Consequently, much of Kevin's youth has been spent in foster homes.

Prior to his commitment to Haverford, Kevin came to the attention of school authorities because of his inappropriate behavior, such as "making weird noises, refusing to do work, and talking back to teachers." A consulting school psychiatrist diagnosed Kevin as a "disturbed child" and recommended placement in Haverford. Kevin's psychological evaluation, performed after his admission to Haverford, describes him as a "very needy, very angry boy" who was "not currently seen as psychotic, although there is a tendency toward projection and a lack of control where anxious." His Admission Note, also prepared after his admission, gives as the "reason for admission:" "Difficulties adjusting to school and family (mother). Exhibited bizarre behavior in school that has included making inappropriate sounds and laughing inappropriately." Kevin's psychological history concludes, "It is felt that much of Kevin's problems come from living with a schizophrenic mother and having a very unstable and abused early life."

Richard S., age thirteen, was committed to Haverford by the county child care agency on June 6, 1976 pursuant to section 201 of the 1976 Act. Richard has spent almost

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ords carefully and considering the memoranda submitted by counsel, we believe that Part A of each of the medical records is relevant to issues in this case and admit those portions into evidence.

all of his life in foster homes and residential homes for difficult children, with the exception of a two-year period between the ages of two and four. His Admission Note for Haverford states, as a reason for admission: "Inability to adjust to an open setting. History of self harm and running away."

Plaintiff James Paul M., age eight, was admitted to Haverford on October 17, 1977, under section 201 of the 1976 Act. His mother had died approximately one year before his admission to Haverford. The stated "reason for admission" to Haverford was "uncontrollable behavior" and "learning disability."

Plaintiff Raymond C., age thirteen, was admitted to Haverford on September 28, 1977, pursuant to section 201 of the 1976 Act. Raymond was admitted initially for purposes of "evaluation." The reason given for his admission was "History of uncooperative disruptive and aggressive behavior including run [sic] away from school. Problems in community with stealing and destroying property. Has a learning and hearing problem."

William B., age nine, was committed to Haverford by his father pursuant to section 201 of the 1976 Act on September 21, 1977. For about two years prior to his commitment, William had been living with his natural father, stepmother, and two stepbrothers. The stated reason for his hospitalization was William's "uncontrollable behavior; preoccupied with matches, set a rug on fire, turned the gas burners on in the house, throws things out the window."

Twelve year old Edward B. was committed to Haverford on May 9, 1977 pursuant to section 201 of the 1976 Act. He has subsequently been discharged from Haverford.

Hospital records show that Edward was not informed that he was to be admitted to a mental health facility prior to his admission date, but rather was told that his parents were taking him to a new school. He was extremely upset by the admission process, expressing fears about being in a hospital with "crazies" and being confined "like a prisoner." The stated reason for his admission was that Edward was "Hyperactive with poor behavioral control; threatens to hurt himself; feels depressed."

Plaintiff Francis B., age ten, was originally admitted to Haverford pursuant to section 403 of the 1966 Act on August 16, 1976. Subsequently, on September 7, 1976, Francis' father executed a form committing Francis to inpatient treatment pursuant to section 201 of the 1976 Act. While no "reason for admission" is given in the Admission Note, the examining physician stated that Francis had "difficulties adjusting to school" and that he has been described as "hyperactive with short attention span." Francis B. has subsequently been discharged from Haverford.

Plaintiff Maria L., age twelve, was admitted to Haverford on April 25, 1977, pursuant to section 201 of the 1976 Act. The Admission Note states that she was admitted because of "difficulties adjusting to school because of aggressive behavior . . . [and] difficulties adjusting within the family." Maria has subsequently been discharged from Haverford.

Plaintiff Thomas W. is eleven years old. He was originally committed to Haverford under section 302 of the 1976 Act (Involuntary Emergency Examination Treatment), which was subsequently changed to a section 201 commitment. The stated reason for admission was

Thomas' violent behavior. Thomas has since been discharged from Haverford.

The three remaining named plaintiffs are committed to institutions for mentally retarded pursuant to the 1966 Act. Plaintiff Nancy Louise D., age seventeen, was admitted to Polk State School and Hospital (Polk)[16] and is being confined pursuant to the terms of the 1966 Act. She was living in a foster home until institutionalized on May 22, 1968. Nancy Louise is categorized as being moderately retarded.

Plaintiff Gina S., age sixteen, was admitted to Polk on October 20, 1970 by her mother. She is currently being confined under section 402 of the 1966 Act. Gina's medical records state that she is functioning in the moderately retarded range of intelligence.

Plaintiff George S., age fourteen, was admitted to Pennhurst State School and Hospital (Pennhurst) on November 5, 1969, under the voluntary admission provisions of the 1966 Act in response to a request by Catholic Social Services. Prior to his admission to Pennhurst, he had been living in a foster home until his foster mother became unable to care for him. George is classified as being severely retarded.

IV. *The Class*

The Supreme Court cautioned that "careful attention must be paid to the differences between the mentally ill and mentally retarded, and between the young and the very

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[16] Nancy Louise D. was admitted to Polk on May 22, 1968. Her application form for admission shows that she was admitted under the authority of the Mental Health Act of 1951, rather than the 1966 Act then in effect.

young." 431 U.S. at 135-36. In response, we have painstakingly reviewed the testimony given at trial and considered as well the supplementary evidence submitted to us on remand.[17] On the basis of the record before us, we find as follows.

As the Supreme Court noted, there are major differences between the mentally ill and the mentally retarded. Mental illness is a term which covers a plethora of problems ranging from severe withdrawal and psychosis, to emotional problems which are situationally based.[18] Mentally retarded persons, on the other hand, are defined as those with substantial intellectual subnormalities, coupled with impairments in adaptive behavior originating in the developmental period.[19] Approximately three percent of the population, or two to three million persons, are classified as mentally retarded. Eighty to eighty-five percent of those are only mildly retarded; however, even those who suffer from a minor impairment are at times institutional-

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[17] The parties stipulated as follows:

> The evidence which was admitted in the initial proceeding, including all testimony, depositions, exhibits, interrogatories, objections and rulings shall be deemed included in the record of these proceedings. Further, for the convenience of the parties and the Court, the printed Appendix, which was used in the Supreme Court, No. 75-1064, with permission of this Court shall be used in these proceedings.

Stipulation of Counsel No. 40, Supplementary Exhibit No. 40.

We accept the Stipulations of Counsel and incorporate them into our findings.

[18] Testimony of J. Feiner, Appendix at 467a, *Kremens v. Bartley*, 431 U.S. 119 (1977) [hereinafter cited as Appendix].

[19] Deposition of L. Glenn at 11. By contrast, a person age twenty who suffered brain damage as a result of an automobile accident would not be considered mentally retarded. *Id.*

ized.[20] Despite these differences between mental illness and mental retardation, the testimony reveals that, with respect to many of the crucial factors which this court must consider in determining procedural due process requirements, there is little difference between the two groups.

First of all, a similar kind of stigma attaches to institutional commitment whether the juvenile is classified as mentally ill or mentally retarded. Experts on mental illness and retardation testified that this stigma is imposed both outwardly, in that juveniles who have been in institutions encounter substantial obstacles in the community,[21] and inwardly, in that the self-image of the juvenile is almost always severely damaged.[22] Mentally retarded children who are institutionalized are often stigmatized as dangerous and aberrant, thus making their subsequent integration into the community even more difficult. Further, these children are deprived of non-handicapped role models and, as a consequence, tend to adopt behavior patterns which are not socially and culturally appropriate. These behavior patterns may continue after a child is released into the community and, in fact, serve to accentuate the existing community stereotype of the mentally retarded.[23]

Second, both mental illness and mental retardation are conditions which are subject to error in diagnosis and iden-

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[20] *Id.* at 9.

[21] *Compare*, Testimony of J. Feiner, Appendix at 474a-75a, *with* Deposition of L. Glenn at 25.

[22] *Compare* Testimony of J. Feiner, Appendix at 474a-75a; Testimony of M. Ingall, Appendix at 595a-96a; and Testimony of E. Messinger, Appendix at 621a-22a *with* Deposition of L. Glenn at 25.

[23] Deposition of L. Glenn at 26-27.

tification. Experts on mental illness in juveniles repeatedly emphasized that the problems of the juvenile are often closely intertwined with mental and emotional problems of other family members. Irrespective of this fact, the juvenile is often the person isolated as having the mental problems.[24]

Errors in identifying mentally retarded juveniles result from different factors. First of all, certain physical characteristics, *e.g.*, Down's Syndrome, have historically been associated with retardation. However, these associations may not necessarily be accurate. Second, certain physical handicaps may cause a person to be mistakenly labelled mentally retarded. An undetected hearing impairment, for example, may prevent a child from performing well on an I.Q. test. A child who lacks normal motor or speech capabilities, who is unable to communicate or behave like other children, may be mistakenly identified as being retarded.[25]

Third, conflicts between the concerns and interests of the parents, and the best interests of the child frequently arise with respect to both mentally ill and mentally retarded children. Experts on mental illness testified that parents often commit their mentally ill children because of pressures in the home related to the child, or because of the parents' inability to cope with the child's problems and lack of awareness of alternatives to institutionalization.[26]

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[24] Testimony of J. Feiner, Appendix at 467a-72a; Testimony of M. Ingall, Appendix at 588a-90a; Testimony of E. Messinger, Appendix at 616a-17a.

[25] Deposition of L. Glenn at 13A-14.

[26] Testimony of J. Feiner, Appendix at 472a-73a; Testimony of H. Kandler, Appendix at 553a-54a.

Similarly, parents of mentally retarded children are frequently subject to community pressure to institutionalize their children.[27] Other personal pressures, such as the parents' own emotional difficulties in dealing with the mentally retarded child, as well as the financial problems of providing necessary care, may cause a parent to institutionalize a mentally retarded child although that course is not in the child's best interests.[28] Finally, the parents simply may not be aware of less drastic alternatives to institutionalization.[29] Because of these potential conflicts between the parent and child, experts who testified on behalf of both mentally ill and mentally retarded children were of the opinion that an impartial third party[30] should make the final decision to institutionalize a child, not only for the child's benefit, but also to reduce the trauma and guilt felt by the parents.[31]

Finally, testimony concerning the nature of the deprivation of liberty inherent in institutionalization and the impact of this deprivation upon the individual is similar for both mentally ill and mentally retarded children.[32]

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[27] Deposition of L. Glenn at 35-36. For example, parents who have not been exposed to mentally retarded children may become upset when their normal child associates with a mentally retarded child, who the parents perceive as being "different."

[28] *Id.* at 37-42.

[29] *Id.* at 57-58.

[30] The experts did not necessarily agree, however, as to the *identity* of the third party. *Compare, e.g.*, Testimony of J. Feiner, Appendix at 478a-79a, *with* Testimony of L. Tashjian, Appendix at 644a-46a, 652a.

[31] Deposition of L. Glenn at 57-58.

[32] *Compare* Testimony of J. Feiner, Appendix at 474a-75a, and Testimony of E. Messinger, Appendix at 620a-22a *with* Deposition of L. Glenn at 22-24.

One expert testified to the "derailment from the usual course of one's life, the dreary regimen even in the most progressive hospitals, the extreme deprivation and limits" which are the effects of institutionalization.[33] Institutions prevent persons from being exposed to normal community experiences and prevent individual growth. With respect to mentally retarded persons, these conditions may be rendered even more acute by the person's inability to protect himself against the dehumanizing effects of institutionalization.[34] Finally, these effects appear to be the same regardless of whether the institution is state-operated or privately-operated; the crucial variable is size.[35]

The ages of the mentally retarded juveniles covered by the 1966 Act range from adolescent to very young. However, we conclude that the same factors hold true irrespective of the child's age. Indeed, the danger of misclassification and the stigma of institutionalization fall more heavily upon the younger child, for whom the decision to institutionalize may effectively foreclose any opportunity to adjust adequately to life in the community. Conversely, there is no evidence to suggest that older mentally retarded juveniles have either a greater or lesser need for procedural due process protection. On the contrary, as with younger juveniles, an older juvenile who is mentally retarded may be functioning under the same disabilities which are pertinent here; that is, he may be unable to read or write, or to understand concepts such as the right to counsel.[36]

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[34] Deposition of L. Glenn at 23-24.

[35] *Id.* at 28. However, the stigma of being labelled mentally ill or mentally retarded remains, regardless of the size of the institution or the actual conditions therein.

[36] *Id.* at 64-65.

Therefore we conclude that the need for due process protection and the factors which this Court must consider in determining what process is due, are the same for older and younger mentally retarded juveniles.

V. *Plaintiff Class Action*

Plaintiffs have requested that they be permitted to bring this action on behalf of two classes in accordance with Fed.R.Civ.P. 23(a) and 23(b)(2).[37] One proposed

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[37] We approved a defendant class pursuant to Fed.R.Civ.P. 23(a) and 23(b)(2) of "directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare" by Order dated March 28, 1978. *Institutionalized Juveniles v. Secretary of Public Welfare*, C.A. No. 72-2272 (E.D. Pa., March 28, 1978). The defendant class representatives are directors of three state-owned and operated facilities and the Secretary of Public Welfare.

The parties have stipulated as follows:

> All mental health and mental retardation facilities in Pennsylvania which are not state-owned and operated must be licensed and/or approved by the Department of Public Welfare. As part of the approval/licensing, such facilities have been required and are required to utilize and act in conformity with the commitment and admission procedures in both the 1966 Act and the 1976 Act.

Stipulation of Counsel No. 37, Supplementary Exhibit No. 13.

This stipulation serves to buttress our conclusion that there is no conflict between defendant class members because "the challenged statutes and regulations are applicable to all of Pennsylvania's mental health institutions, whether state-owned and operated, or privately-owned." *Institutionalized Juveniles v. Secretary of Public Welfare, supra.*

This stipulation also serves to distinguish the case before us from *In Re John S.*, 135 Cal. Rptr. 893 (Ct. App. 1977), where the court held that there was no state action present in a parent's de-

class would consist of juveniles committed as mentally ill and who are under age fourteen; the other class would be juveniles committed as mentally retarded who are age eighteen or younger. Mindful of the Supreme Court's instructions that we " 'stop, look, and listen' before certifying a class in order to adjudicate constitutional claims," we proceed to determine if these proposed classes may be properly maintained.

A. *Mentally Ill Juveniles Under Age Fourteen*

One proposed class consists of all juveniles under the age of fourteen who are subject to inpatient treatment under Article II of the 1976 Act. We conclude that the class meets the requirements of Rule 23.

This class consists of approximately 360 members[38] which is sufficient to meet the numerosity requirements of Rule 23 (a).

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cision to admit their minor child to a private mental hospital. The *John S.* court specifically held that the state "does not control either admissions or treatment policies of the private hospital to which [the] minor was admitted." *Id.* at 901. Therefore, since the parents had not invoked the aid of a state statute in committing their child to a private mental hospital, the state was in no way a party to the parental decision. *Id.* We believe that the situation in Pennsylvania, as reflected by this Stipulation of Counsel, mandates a different conclusion. Since the state actively regulates the admissions procedures of all mental health facilities within the state as part of its licensing power, children, who are "voluntarily" admitted to privately-owned facilities are confined pursuant to state law.

[38] See Exhibits A and B to Stipulation of Counsel, Supplementary Exhibit No. 13 (Defendants' Answers to Plaintiffs' Interrogatories).

The question of law common to all class members is the facial validity of those provisions of Article II of the 1976 Act which relate to the voluntary commitment of mentally ill juveniles under the age of fourteen.

Rule 23 (a) requires that the claims of the representative parties be "typical" and that those parties adequately represent the interests of absent class members. While it has been noted that there is difficulty in distinguishing between "typicality" and "adequacy" requirements, those two criteria may be taken in concert as requiring that (1) the named plaintiffs be members of the class; (2) the named plaintiffs have no interests antagonistic to those of absent class members; and (3) the named plaintiffs' attorney be qualified, experienced and generally able to conduct the proposed litigation.[39] *See Wetzel v. Liberty Mutual Insurance Co.*, 508 F.2d 239 (3d Cir. 1975); *Eisen v. Carlisle & Jacquelin*, 391 F.2d 555 (2d Cir. 1968); 3B J. Moore, Federal Practice ¶23.07[1] (2d ed. 1977).

Nine of the named plaintiffs are juveniles committed as mentally ill who are under the age of fourteen; thus, they clearly are members of the class. There is no conflict between these plaintiffs and absent class members. Each class member, irrespective of that child's age, is confined under the same statutory provisions alleged to be unconstitutional. Therefore we conclude that the class itself is cohesive and free from conflict, and that the representative

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[39] We have no doubts concerning the caliber of representation provided by plaintiffs' counsel, as evidenced by the high degree of competence displayed by counsel throughout the course of this litigation.

plaintiffs, through counsel, will adequately and vigorously represent the interests of absent class members.[40]

Finally, the class meets the requirements of Rule 23 (b) (2), since "the party opposing the class has acted or refused to act on grounds generally applicable to the class," thereby making declaratory or injunctive relief with respect to the entire class appropriate. *See Goldy v. Beal*, 429 F. Supp. 640 (M.D. Pa. 1976) (three-judge court). We find, therefore, that this action may be maintained as a class action on behalf of all juveniles committed as mentally ill who are under the age of fourteen.

B. *Mentally Retarded Juveniles Age Eighteen Or Younger*

Plaintiffs also seek to maintain this action on behalf of a class of mentally retarded juveniles age eighteen or younger. This entire class is covered by the 1966 Act; however, as noted above, juveniles age thirteen and over are given additional protection by the 1973 Regulations. The Supreme Court expressly posed the question of whether differences between older and younger juveniles might render certification of a class embracing both groups improper. 431 U.S. at 135. Because of our finding that there are no significant differences between older and younger mentally retarded juveniles for due process purposes, and for other reasons stated below, we conclude that the applicable Rule 23 criteria are met.

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[40] Plaintiffs' counsel was appointed guardian *ad litem* for the the class in order to alleviate any potential problem caused by the difficulty of the class representatives, persons confined to mental institutions, to fairly and adequately represent the interests of the class. *See Goldy v. Beal*, 429 F.Supp. 640, 649 (M.D. Pa. 1976) (three-judge court).

This class consists of approximately 3,153 members,[41] which is clearly sufficient to meet Rule 23 (a) 's numerosity requirement. Of greater concern is the requirement that there be questions of fact and law common to all class members, since mentally retarded juveniles who are thirteen and over are given greater procedural protection pursuant to the 1973 Regulations than younger juveniles. However, the attack mounted here is against the entire statutory scheme, including both the applicable provisions of the 1966 Act and the 1973 Regulations. We have previously made a finding that, for procedural due process purposes, there are no significant differences between older and younger mentally retarded juveniles. Therefore, if the statutory scheme is unconstitutional with respect to the older juveniles who receive greater protections, then it is *a fortiori* unconstitutional with respect to the younger juveniles who receive far less protection.

The "typicality" and "adequacy of representation" requirements are also met. The named plaintiffs here are all age thirteen or older and are thus given greater protections under the 1973 Regulations than class members under age thirteen. However, all three mentally retarded plaintiffs were admitted to their respective institutions before they reached age thirteen and, therefore, were presumably not accorded the additional procedural safeguards at the date of their admission. Furthermore, we do not believe that the rights accorded to older juveniles following their admission, such as the right to request a hearing on the validity of their confinement, serve to create a conflict between the

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[41] *See* Exhibits A and B to Stipulation of Counsel, Supplementary Exhibit No. 13 (Defendants' Answers to Plaintiffs' Interrogatories).

older and younger juveniles.[42] First of all, we reiterate our conclusion that due process requirements are the same for both groups. Second, we note that, in order for the named plaintiffs to prevail on their claim that the statutory scheme is unconstitutional, it will be necessary for them to prove the unconstitutionality of the statute and regulations as applied to the less protected younger retarded juveniles.[43] Therefore, we conclude that this action is properly brought on behalf of a class of mentally retarded juveniles age eighteen or younger.

VI. *Discussion*

In our original decision, we concluded that the plaintiffs had a liberty interest, protectible under the Fourteenth Amendment, in not being institutionalized without due

[42] There is nothing in the record to show whether notice of these additional rights was given to the juveniles at any time after their thirteenth birthday. Indeed, it is unclear from the text of the 1973 Regulations whether they provide that a juvenile who attains the age of thirteen while institutionalized must be given notice of his additional rights at that time. *See* note 10, *supra*.

[43] We do not believe that it is necessary for the class representatives to have interests identical in every respect to all class members in order to adequately represent the class. What is important is that their interests be the same with respect to the rights sought to be asserted. "Whether a party adequately represents a class depends on all the circumstances of the particular case." *Wetzel v. Liberty Mutual Insurance Co.*, 508 F.2d 239 (3d Cir. 1975) (former employees who voluntarily terminate their employment are able to represent adequately a class of presently employed persons, absent a showing of genuinely antagonistic interests.) Where, as here, there is no conflict between the interests of the representative plaintiffs and the absent class members, and the circumstances clearly demonstrate that the representative plaintiffs will vigorously assert the interest of all class members, we believe that the class action is properly maintained.

process of law. 402 F.Supp. at 1046. Encompassed within this liberty interest is not only protection against physical restraint and confinement, but also protection of the juvenile's "good name, reputation, honor, [and] integrity." *Wisconsin v. Constantineau*, 400 U.S. 433 (1971), *cited in Bartley v. Kremens, supra*, 1046 n. 8. The protection of the plaintiffs' reputation interest is implicated because of the stigma attached to institutional commitment, a stigma which "may render civil commitment a more lasting abridgement of personal freedom than imprisonment for a crime." *Id.* at 1046. We reaffirm these conclusions.

We further determined that this liberty interest could not be waived by plaintiffs' parents, guardians, or persons standing *in loco parentis*. *Id.* at 1047. There may be instances where the congruence between the parents' interests and those of the child assure that the parents will arrive at a decision based upon the best interests of the child.[44] The evidence in this case overwhelmingly demonstrates that, due to the substantial potential for conflict between the interests of the parent and the child, this is not such a situation. *See New York State Association for Retarded Children v. Carey*, 357 F.Supp. 752, 762 (E.D. N.Y. 1973); *cf. Horacek v. Exxon*, 357 F.Supp. 71, 74 (D. Neb. 1973).

It has been argued that the parents' determination that institutionalization is the appropriate treatment for a child believed to be mentally ill or retarded is no different from the decision to provide any other type of medical treatment. We disagree. Unlike other kinds of medical treatment, a

[44] We do not mean to imply, however, that in such a case parents necessarily would have the right to waive the constitutional rights of their children.

substantial stigma attaches to institutionalization. This stigma coupled with the substantial danger of error in the diagnosis of mental illness and mental retardation, and the greater potential for long-term loss of liberty[45] create a situation substantially different from the treatment of other medical conditions. Furthermore, we perceive little or no parent-child conflict in the decision to give or withhold other kinds of medical treatment since a parents' interests are more likely to be similar to the best interests of the child. Therefore, we reaffirm our holding that parents may not waive the constitutional right of their child not to be deprived of liberty without due process of law.

We then turned to a consideration of what process was due. In responding to plaintiffs' allegation that they were deprived of certain specific procedural rights, we concluded that the juvenile plaintiffs were entitled to

> (1) a probable cause hearing within seventy-two (72) hours from the date of their initial detention; (2) a post-commitment hearing within two (2) weeks from the date of their initial detention; (3) written notice,[46] including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment; (4) counsel at all significant stages of the commitment process and if

[45] The testimony demonstrated that, with respect to mentally retarded children, the decision to institutionalize is often a long-term or even life decision. Deposition of L. Glenn at 52-53.

[46] Because of those cases where notice to the child might be meaningless, we found that, "until some other procedure is established, this notice shall be sent not only to the child but also to the Clerk of the Court with jurisdiction and shall be forwarded to the child's attorney." 402 F.Supp. at n. 19.

> indigent the right to appoint free counsel;[47] (5) be present at all hearings concerning their proposed commitment; (6) a finding by clear and convincing proof that they are in need of institutionalization; (7) the rights to confront and cross-examine witnesses against them, to offer evidence in their own behalf, and to offer testimony of witnesses.[48]

402 F.Supp. at 1053. While we set forth these detailed procedures, we also stated, "Our action is not intended to preempt the state which is free to develop its own safeguards so long as they are as fully effective as those which we set out." *Id.* at n. 16, *citing Miranda v. Arizona,* 384 U.S. 436 (1966) and *Morrissey v. Brewer,* 408 U.S. 490 (1971).

[47] It may not always be necessary to appoint a lawyer so long as a substitute procedure adequately protects the child's interest. For example, it may be sufficient to appoint a guardian, trained in the mental health field, who would advocate the child's interests or alternatively, have the power to retain a lawyer to do so. The important point is that the child must have a capable advocate who has the sole responsibility of advancing the child's best interests. However, until alternative procedures are designed which will adequately protect the child's interests, we adhere to our conclusion that counsel is required.

[48] We further noted that "we neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made." 405 F.Supp. at n. 26. Except with respect to the right to notice and counsel, we concluded that "any or all of these rights may be waived by the child and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them." *Id.* We further concluded that, in the case where a child is unable to understand his rights, the attorney may waive these rights, and "the unbiased tribunal may accept the waiver upon a finding that the waiver is appropriate." *Id.*

To rephrase Judge Friendly, there is no single correct solution to the problem of safeguarding the interests of the juvenile plaintiffs; "more of one procedural safeguard may justify less of another." Friendly, *Some Kind of Hearing*, 123 U.Pa.L.Rev. 1267, 1302 (1975).

We reaffirm these conclusions, and make the following additions and clarifications. First, we reiterate the need for a hearing in all cases unless there is a valid waiver. The Supreme Court has dictated that, in identifying the specific content of due process, three factors must be considered: the private interest involved, the risk of erroneous deprivation, and the Government's interest, including any fiscal and administrative burdens that the additional procedures would entail. *Smith v. O.F.F.E.R.*, 431 U.S. 816 (1977); *Mathews v. Eldridge*, 424 U.S. 319 (1976). The juvenile's interest here is weighty, and the risk of erroneous deprivation, as noted earlier, is great.[49] We believe that a hearing would insure that the interests of the child are clearly represented, that alternatives to institutionalization are fully explored, and that the decision to commit the child is impartially made.[50] *See J. L. v. Parham*, 412 F.Supp. 112

[49] The Supreme Court recently emphasized the importance of preventing erroneous deprivations of protected rights, stating:

> Procedural due process rules are meant to protect persons not from deprivation, but from the mistaken or unjustified deprivation of life, liberty, or property. Thus, in deciding what process constitutionally is due in various contexts, the Court repeatedly has emphasized that "procedural due process rules are shaped by the risk of error inherent in the truth-finding process. . . ."

Carey v. Piphus, 46 U.S.L.W. 4224, 4227 (March 21, 1978) (citations omitted).

[50] Several experts testified concerning the function that a hearing would serve. *See, e.g.*, Deposition of L. Glenn at 55-59; Testimony of E. Messinger, Appendix at 623a-25a.

(M.D. Ga. 1976) (three-judge court); *Lynch v. Baxley*, 386 F.Supp. 378 (M.D. Ala. 1974).

Several issues should be considered at the hearing. First, the unbiased tribunal should determine whether, in fact, the child is mentally ill or mentally retarded. If this determination is affirmative, the tribunal should proceed to determine if commitment is necessary, if it will be beneficial to the child, and if it is the least restrictive alternative. *J. L. v. Parham, supra; Halderman v. Pennhurst State School and Hospital*, C.A. No. 74-1343 (E.D. Pa., December 23, 1977). Where the state sanctions the restriction of a child's liberty rights, such restriction should intrude upon those rights to the smallest possible degree necessary for the achievement of the purposes of the restriction. *Shelton v. Tucker*, 364 U.S. 479 (1960). *See Halderman v. Pennhurst State School and Hospital, supra*, and cases cited therein. While the tribunal should make findings to support its determination, these findings need not necessarily be made formally. It is crucial, however, that the tribunal make a good faith, independent determination that the above criteria are met before a juvenile is confined.

We reject the argument that a hearing should not be required because it might prove traumatic for the child. First of all, the expert testimony, for the most part, demonstrated that the effects of a hearing on the child and, in many cases, the parent would be beneficial.[51] For example, one expert testified, with respect to mentally re-

[51] Several experts testified that a hearing would serve a therapeutic function in some instances, in that the child would thereby be assured that the decision to commit him was made fairly and impartially. Testimony of J. Feiner, Appendix at 483a-84a; Testimony of H. Kandler, Appendix at 544a.

tarded children, that a hearing would enhance feelings of dignity and self-worth in the child, reduce the guilt feelings of the parents, and reduce interfamilial conflicts, if any exist, over whether the decision to commit the child is correct.[52] Secondly, we note that the attorney representing the child has the option of waiving the child's presence at the hearing if there is a potential for trauma, and the court may accept such waiver where the child's interests are not compromised. Finally, and danger of trauma pales beside the potential severity of the deprivation of liberty suffered by a child needlessly institutionalized. *See Dixon v. Attorney General,* 325 F.Supp. 966 (M.D. Pa. 1971) (three-judge court).

Finally, with respect to the nature of the tribunal, we state only that the tribunal must be neutral and unbiased. It is clear that "an unbiased tribunal is a necessary element in every case where a hearing is required." Friendly, *Some Kind of Hearing,* 123 U.Pa.L.Rev. 1267, 1279 (1975). Whether the tribunal should be judicial or administrative is not a matter best resolved by this Court at this time.[53]

In view of the guidelines set forth above, we turn to the specific provisions attacked here; namely, the 1973 Regulations and the 1976 Act.

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[52] Deposition of L. Glenn at 56-57.

[53] In our initial opinion, we stated, "Until the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearing the present facilities of the Commonwealth court system shall be used for these hearings." 402 F.Supp. at 18.

We have reconsidered this portion of our original opinion and conclude that the more prudent course of action is to permit the Commonwealth to determine what kind of "unbiased tribunal" should conduct these hearings.

a. *1973 Regulations*

As outlined above, these regulations augment the procedures of the 1966 Act, giving certain procedural rights to all juveniles and other additional rights to juveniles age thirteen and over. Since the passage of the 1976 Act, these provisions apply only to those juveniles who are mentally retarded. We conclude that these 1973 Regulations are not in accord with the requirements of due process.

One of the major deficiencies[54] of the 1973 Regulations is the absence of a procedure designed to achieve informed, impartial admissions. Under the Regulations, a juvenile under the age of eighteen may be admitted to an institution upon the referral of either a pediatrician, general physician, or psychologist,[55] with the concurrence of the Director of the Institution.[56] The referring pediatrician or general physician may have no knowledge or training

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[54] This discussion is not meant to be an exclusive listing of the procedural deficiencies of the 1973 Regulations. To the extent that the Regulations do not fulfill the requirements stated elsewhere in the text, we hold that they are unconstitutional.

[55] Under the 1973 Regulations a mentally retarded juvenile may be referred to either a "recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency. . . . a pediatrician, or general physician or psychologist."

The Regulations required that referral of mentally ill juveniles, no longer covered under the Regulations, be accompanied by a psychiatric evaluation, stating "with specificity the reasons that the person requires institutional care." However, the 1973 Regulations permit "a medical or psychological evaluation" to accompany the referral of a mentally retarded juvenile. Further, it is not clear whether these "medical or psychological evaluations" must state the reasons for institutionalization "with specificity."

[56] The Regulations require the Director of the Institution to conduct his own independent examination of the juvenile.

whatsoever concerning the problems of mental retardation,[57] while the Director of the Institution, who has interests different from those of the child, may be placed into a position of conflict in making the decision to commit.[58] There is no assurance whatsoever that the interests of the

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[57] Plaintiff's expert on mental retardation testified that, since mental retardation is not a medical problem, physicians typically are not familiar with developments in the delivery of services to mentally retarded persons. Deposition of L. Glenn at 49. Other mental health professionals often make institutional referrals because of the pressures on them to find rapid placement for mentally retarded children. *Id.* at 50-51.

[58] Many of the experts commented on the conflict of interest which faces the Director of a mental institution in this context. *See, e.g., id.* at 46; Testimony of E. Messinger, Appendix at 629a-30a Dr. Messinger summarized these conflicts as follows:

> [P]sychiatrists are people, too, and we are influenced by considerations other than those that are strictly clinical. For example, if I, as director of a state hospital get a letter from a colleague in a community facility, saying that John Doe really needs psychiatric hospitalization and is severely disturbed, even if I felt otherwise from a direct discussion with the patient, I would be in an awkward position if I said, "No, this patient does not require hospitalization." What do I then say to my colleague whose opinion I disagreed with?
>
> Secondly, professionals—psychiatrists who work for institutions, are influenced by the needs of the institution, as well as the needs of the individual patient. If I am the director of an adolescent service and the funding of my unit depends on how fully utilized the unit is, I might be on the side of admitting the adolescent. I am not saying this is done deliberately, but I think that a decision as complex as hospitalization is influenced by factors within the psychiatrists at a number of different levels and such considerations as bed utilization will play some role.

Id.

child will be weighed in making this decision. Therefore, this procedure does not provide the protections furnished by hearing before an "unbiased tribunal".

As for the additional procedural rights given to children age thirteen and older, we conclude that there are severe deficiencies in these procedures as well. First of all, the mentally retarded child who receives written notice may not be able to read the notice or comprehend the explanation of his rights contained therein. Assuming that the child does understand the notice, however, the burden of commencing the enumerated procedures rests with the juvenile; he must contact counsel or object to the institutionalization. As one of the experts testified, "It's putting an awful lot of burden on young retarded persons to stand up against a big institution." Deposition of L. Glenn, at 67. Once the child protests, there is no set time limit in which a hearing must be held. We believe that, especially in the case of retarded children, who may lack the ability to understand the notice given to them due process rights are violated in the absence of an automatic post-commitment hearing, to be scheduled within a reasonable time, and the presence of counsel to speak solely for the child's interests.[59] Therefore, we hold that the 1973 Regulations fall short of the minimum due process requirements we outlined above.

b. *1976 Act*

Article II of the 1976 Act, as noted above, specifies certain procedures for the voluntary "inpatient treatment" of mentally ill juveniles who are age thirteen or younger. We believe that these procedures do not meet due process standards.

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[59] We in no way imply, however, that the other rights we have enumerated do not also apply.

We will note specifically several of the deficiencies of the 1976 Act. The major deficiency is the absence of a required post-commitment hearing to be held within a reasonable time after commitment and the absence of counsel to advocate the interests of the child.[60] We believe that these procedural requirements are especially critical where, as here, the rights of very young children may be implicated. These mentally ill children may lack the ability and capacity to speak on their own behalf, as an older juvenile might be able to do, and their interests may be overlooked.[61]

The procedures governing withdrawal from inpatient treatment in no way cure the defects of the statute. Section 206(b) provides that "any responsible party" may

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[60] The Act does provide that "an individualized treatment plan" be formulated by a "treatment team." The Act further states that "A treatment team must be under the direction of either a physician or a licensed clinical psychologist and may include other mental health professions." 50 P.S. §7106. There is no assurance of the treatment teams' independence from the inpatient facility into which the child is being committed; and, in fact, the medical records of the named plaintiffs in this case appear to demonstrate that the members of the treatment team are employed by or associated in some way with the admitting institution. Therefore, we believe that this portion of the 1976 Act, is essentially no different from the similar requirement of the 1972 Regulations that the Director of the Institution examine all juveniles referred to him before admitting them.

[61] One of the experts testified, with respect to mentally ill juveniles

> I think in fact that the need for a hearing in the younger children is greater, because one cannot expect them to understand fully, certainly in legal terms, their dilemma, nor can they be aware of alternative forms of therapy. . . . I think that because younger children are less sophisticated and less knowledgeable, that we have to bend over backwards to protect their rights.

Testimony of E. Messinger, Appendix at 631a.

petition the Juvenile Division of the Court of Common Pleas for the modification of or withdrawal from treatment, and at that time, a hearing will be held. Thus, again, rather than providing for automatic procedures aimed at protecting against an unconstitutional deprivation of liberty, the statutory scheme places the burden upon a "responsible party" to initiate the procedures to which the juvenile is entitled. This type of statutory scheme is unacceptable.

Accordingly, we declare that the procedures for voluntary commitment of mentally ill and mentally retarded juveniles, as set forth in the 1966 Act, the 1973 Regulations, and the 1976 Act, are unconstitutional on their face and as applied to plaintiffs, and enjoin their enforcement.[62]

We continue to retain jurisdiction over this action, as we have the inherent power to do. This will enable the parties to apply for amendment or modification of the Order of they deem it necessary.[63]

John J. Gibbons
C.J.
Daniel H. Huyett, 3rd
D.J.

Honorable Raymond J. Broderick dissents and will file a dissenting Opinion.

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[62] The foregoing shall constitute findings of fact and conclusions of law as required by Fed.R.Civ.P. 52(a).

[63] We have issued a detailed Order in compliance with Fed.R. Civ.P. 65(d) and the Supreme Court's decision in *Schmidt v. Lessard*, 414 U.S. 473 (1974).

IN THE UNITED STATES DISTRICT COURT FOR EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S.; by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated

v.

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated

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ORDER

NOW, May 25th, 1978, for the reasons set forth in the accompanying Opinion, IT IS ORDERED that judgment is entered in favor of plaintiffs and against defendants. In accordance with Fed. R. Civ. P. 58 and 65(d), we set forth below the terms of the injunctive relief granted.

CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b)(2). Two classes are represented by the named plaintiffs:

(a) all juveniles committed as mentally ill to mental health facilities in Pennsylvania who are under the age of fourteen;

(b) all juveniles committed as mentally retarded to mental health facilities in Pennsylvania who are age eighteen or younger.

2. This action is properly maintained as a defendant class action under Fed. R. Civ. P. 23(b)(2). The class represented by the named defendants includes directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare.

DECLARATORY JUDGMENT

3. Section 402(a)(2), section 402(c) and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (1966 Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

4. Section 201, section 206(d), and, to the extent that it applies to juveniles under the age of 14, section 205 of the Mental Health Procedures Act of 1976 (1976 Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

5. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to require that mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under the age of fourteen receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other trained representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing.

Counsel

6. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel or other trained representative for mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under the age of fourteen; or if the child is indigent, the appointment of free counsel or other trained representative.

Presence of Child

7. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to afford to mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under the age of fourteen who are subject to commitment hearings the rights to be present with counsel or other trained representative, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

Standard of Proof

8. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a mentally retarded juvenile eighteen years of age or younger or a mentally ill juvenile under age fourteen, find by clear and convincing proof that the juvenile is in need of institutionalization.

Probable Cause Hearing

9. These sections of the 1966 Act and the 1976 Act are declared invalid in that they permit detention of mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under age fourteen for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 5 through 7 above.

Full Commitment Hearing

10. These sections of the 1966 Act and the 1976 Act are declared invalid in that in the event the initial hearing determines the existence of probable cause, they fail to afford to mentally retarded juveniles eighteen years of age or younger or mentally ill juveniles under age fourteen a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 5 through 8 above.

Regulations

11. The regulations promulgated by defendant Secretary of Public Welfare to supplement the 1966 Act, published at 3 Pa. Bull. 1840 (1973 Regulations), are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all mentally retarded juveniles eighteen years of age or younger the rights delineated in paragraphs 4 through 9 above.

Admissions and Commitments of Plaintiffs

12. It is declared that all mentally retarded juveniles eighteen years of age or younger admitted or committed to mental health or mental retardation facilities in Pennsylvania under the enumerated sections of the 1966 Act are unconstitutionally held and detained.

13. It is declared that all mentally ill juveniles under age fourteen admitted to mental health facilities in Pennsylvania under the enumerated sections of the 1976 Act are unconstitutionally held and detained.

Application for Treatment of Juveniles

14. It is declared that a parent, guardian, or person standing *in loco parentis* may initiate the temporary detention of a mentally retarded juvenile eighteen years of age or younger or a mentally ill juvenile under age fourteen in a mental health or mental retardation facility if the procedures and requirements of our Opinion and Order are fully complied with.

Requirements for Commitment

15. It is declared that all mentally retarded juveniles eighteen years of age or younger and mentally ill

juveniles under age of fourteen, who have been, are, or may be subject to admission or commission to a mental health or mental retardation facility in Pennsylvania are entitled to:

Notice

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other trained representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney.

Counsel

B. Counsel or other trained representative during all significant stages of the commitment process; if the juvenile is indigent, counsel or other trained representative shall be provided for free.

Presence of Juvenile and Other Hearing Rights

C. Presence of the juvenile at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

Standard of Proof

D. A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

Probable Cause Hearing

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

Full Commitment Hearing

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

Waiver

16. Excepting the rights to notice and to counsel or other trained representative, any or all of the rights delineated in paragraph 15 may be waived by the juvenile, and the neutral tribunal may accept such a waiver upon approval by the juvenile's counsel of other trained representative and upon a finding that the juvenile understands his rights and is competent to waive them. Because there may be situations where the juvenile either does not understand his rights or is not competent to waive them, any or all of these rights, excepting the rights to notice and to counsel or other trained representative, may also be waived by the juvenile's attorney or representative, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

INJUNCTIVE RELIEF

17. It is ordered that the operation of section 402(a)(2), section 402(c), and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (1966 Act) is enjoined in that these sections of the 1966 Act are unconstitutional on their face and as applied under the due process clause of the Four-

teenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any juvenile eighteen years of age or younger under the 1966 Act to any mental health or mental retardation facility unless the juvenile is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney or other trained representative.

(2) Counsel or other trained representative during all significant stages of the commitment process; if the juvenile is indigent, counsel or other trained representative shall be provided free.

(3) Presence of the juvenile at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

4. A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and to counsel or other trained representative, any or all of the rights delineated in paragraph 16(a) may be waived by the juvenile, and the neutral tribunal may accept such a waiver upon approval by the juvenile's counsel or other trained representative and upon a finding that the juvenile understands his rights and is competent to waive them. Because there may be situations where the juvenile either does not understand his rights or is not competent to waive them, any or all of these rights, except the rights to notice and to counsel or other trained representative may also be waived by the juvenile's attorney or other representative, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

18. It is ordered that the operation of section 201, section 206(b), and, to the extent that it applies to juveniles under the age of fourteen, section 205 of the Mental Health Procedures Act of 1976 (1976 Act) is enjoined in that these sections are unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment of the United States Constitution. It is further ordered that the defendants and their

officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any juvenile under the age of fourteen under the 1976 Act to any mental health or mental retardation facility unless the juvenile is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney or other representative.

(2) Counsel or other trained representative during all significant stages of the commitment process; if the juvenile is indigent, counsel or other representative shall be provided free.

(3) Presence of the juvenile at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and to counsel or other trained representative, any or all of the rights delineated in paragraph 17(A) may be waived by the juvenile, and the neutral tribunal may accept such a waiver upon approval by the juvenile's counsel or other representative and upon a finding that the juvenile understands his rights and is competent to waive them. Because there may be situations where the juvenile either does not understand his rights or is not competent to waive them, any or all of these rights, excepting to notice and to counsel or other trained representative may also be waived by the juvenile's attorney or other representative, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

19. It is further ordered that the defendant Secretary of Public Welfare and its officers, agents, servants, employees, successors, and those persons in active concert, or participation with them are enjoined:

Regulations

A. To promulgate and issue regulations and to publish them, within sixty (60) days as immediately effective requiring that all mental health and mental retardation facilities in Pennsylvania (see 50 P.S. §4102 and §7103 for the definition of "facility") adhere to the Opinion and Order in this action.

Notice of Order

B. To give notice forthwith to all state school and mental hospital directors and their delegates and all directors of all other mental health and mental retardation facilities in Pennsylvania of the Opinion and Order in this action.

Procedures for Children Already Admitted or Committed

C. To initiate procedures, commencing immediately, to assure that all juveniles eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 of the 1966 Act and all juveniles under age fourteen committed pursuant to §201 of the 1976 Act are either discharged or released or recommitted according to the procedures required by our Opinion and Order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and eighty (180) days of the date of this Order, unless an extension is granted by this Court for good cause shown. Notation shall be made upon the medical records of such juveniles that their discharge, release, or recommitment was effected pursuant to the Opinion and Order in this action.

Reports on Implementation

D. To report to this Court within ninety (90) days and again within two hundred and ten (210) days on

the steps taken and progress made in the implementation of our Opinion and Order. The two hundred and ten-day report shall describe, for each mental health or mental retardation facility, the number of juveniles released, discharged or recommitted.

John J. Gibbons
C.J.

Daniel H. Huyett 3rd
D.J.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

Before: John J. Gibbons, *Circuit Judge*, Daniel H. Huyett, 3rd and Raymond J. Broderick, *District Judges*.

BRODERICK, J., *dissenting*, June 14, 1978:

In 1975, this three-judge court held that the Pennsylvania statutes providing for the voluntary admission and commitment of juveniles to mental health facilities pursuant to the Pennsylvania Mental Health and Mental Retardation Act of 1966 were unconstitutional. *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975). I dissented from that decision. *Id.* at 1054. On appeal, the Supreme Court vacated and remanded for further consideration on the ground that subsequent to this Court's decision, the Pennsylvania legislature enacted the Mental Health Procedures Act of 1976 which gives substantially greater procedural protections to the mentally and emotionally distressed admitted to mental health facilities. *Kremens v. Bartley*, 431 U.S. 119 (1977).

In remanding, the Supreme Court stressed that "careful attention must be paid to the differences between mentally ill and mentally retarded." *Id.* at 135-6. Although courts and legislators have in many instances failed to distinguish between the mentally and emotionally ill and the mentally retarded, there is no question that mental illness and mental retardation are separate and distinct conditions which require different treatment and/or habilitation. In keeping with the Supreme Court's mandate, we will discuss first the mentally retarded.

Mental retardation is an impairment in learning capacity and adaptive behavior. The legislation in question and the professionals in the field consider retardation as being distinct and separate from mental and emotional illness. There is no question, however, that the retarded, just as all members of society, may also suffer mental and emotional illnesses. The habilitation of the mentally retarded is primarily an educational and training process. Mental retardation is not an illness to be treated with drugs and the therapies which have been developed for the mentally and emotionally ill. Today, all experts in the field of mental retardation agree that with proper habilitation, the level of functioning of every retarded person is capable of improvement.

Mental Health and Mental Retardation Act of 1966, 50 P.S. §§4100 et seq.

The statutes and regulations with respect to the voluntary admission and voluntary commitment of the retarded are the same statutes and regulations which were considered by this Court in the *Bartley* case. Sections 402 and 403 of the Act, which are presently applicable to the retarded only, provide that retarded individuals, age eighteen or younger, may be admitted or committed to a mental health facility upon the application of a parent, guardian, or person standing in loco parentis, and such a retarded juvenile is not free to withdraw from the facility without the consent of the parent, guardian, or person standing in loco parentis or his or her successor. Upon receipt of such an application on behalf of a juvenile for voluntary admission or commitment, the director of the facility must cause an examination to be made, and if it is determined that the retarded juvenile is in

need of care or observation, he or she may be admitted to the facility.[1]

Section 402 provides that at least annually, the admission must be reviewed by a committee, appointed by the director from the professional staff of the facility, to determine whether continued care is necessary, and at least every sixty days the juvenile is to be informed of the voluntary nature of his or her status at the facility.

The 1973 regulations, promulgated pursuant to the Act, specify the procedural rights of the retarded aged eighteen or younger. 3 *Pa. Bulletin* 1840 (1973). These regulations provide that the retarded juvenile must be referred to the mental health facility by a mental health professional, pediatrician, general physician, or psychologist, and such referral must include a psychiatric, medical or psychological evaluation stating specifically the reasons why the retarded juvenile requires "institutional care." The regulations also provide that the "Director of the Institution or his delegate, shall have conducted an *independent* examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile." The regulations do not specify when this examination must

[1] The legislature chose to pass two distinct statutes, one of which deals with voluntary admissions to a facility, §402, while the other is concerned with voluntary commitments, §403. Apparently, the main distinction in the two statutes is that under the latter section dealing with voluntary commitments, the initial commitment is for a period not to exceed thirty days, with successive periods not to exceed thirty days each, so long as care or observation is necessary. The section providing for voluntary admissions contains no corresponding time limitation following admission to a facility.

be conducted. They do, however, provide that a retarded juvenile thirteen years of age and older must receive, within twenty-four hours after admission to a mental health facility, written notification explaining his or her rights and furnishing him or her with the telephone number of counsel whom the juvenile may call for representation. In the event such a retarded juvenile objects to remaining at the institution, the director of the institution must notify within two business days the parent, guardian, or person standing in loco parentis, the referral unit and the above designated counsel in order that an involuntary commitment proceeding may be instituted pursuant to §406 of the Act. Neither the regulations nor the statutes provide with the §406 hearing shall be held. Nor do they make provision for the situation in which the retarded individual is unable to understand, and hence utilize, these protections.

There are grave questions concerning the constitutionality of any statute which provides for the "commitment" of a retarded child. Throughout history the retarded have been mistreated and their dire need for education and training ignored. Wolfensberger, *The Origin and Nature of Our Institutional Models* 3 (1975). Retarded children, children mentally and emotionally ill, and children adjudged delinquent, in many instances have been confined to the same institution. Only in relatively recent years have our legislative bodies and our courts recognized the distinction between the retarded, the mentally and emotionally ill and the law breakers. Mental retardation is not a violation of the law. Being mentally retarded does not make juveniles or adults dangerous to themselves or to others. The mentally retarded are persons who because of circumstances beyond their control,

are unable to function at the same educational and behavioral levels as others in society. They do require specialized education, training and care. This Court in *Pennsylvania Association of Retarded Children v. Commonwealth of Pennsylvania,* 343 F. Supp. 279 (E.D. Pa. 1972), recognized that they have a constitutional right under the Equal Protection Clause of the Fourteenth Amendment to receive at least as much education and training as being given by the Government to others not retarded. All of this raises the question as to whether the retarded—persons who have not violated any laws, who are not dangerous to themselves or society and whose only need is for education, training and care—should be subjected to a court proceeding the end result of which is "commitment".[2] I readily agree that this question has not been briefed in this litigation and has not been presented for determination; but it does lend focus to the issues herein presented.

The majority opinion concludes that §§402 and 403, as supplemented by the 1973 regulations, are unconstitutional in that they do not provide sufficient due process safeguards. I am in complete agreement that the retarded have a constitutional right to education and training in the least restrictive setting. As found in *Halderman v. Pennhurst State School and Hospital,* 446 F. Supp. 1295, 1318 (E.D. Pa. 1977), institutionalization in an institution such as Pennhurst State School and Hospital (one of the two institutions in which named retarded plaintiffs reside) is not the least restrictive setting for the

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[2] *See* Herr, *Rights into Action: Protecting Human Rights of the Mentally Handicapped,* 26 Catholic University L.Rev. 203, 308 (1977).

habilitation of the retarded and minimally adequate habilitation cannot be provided there. However, saddling retarded juveniles with the additional due process protections mandated by the majority's order will do little if anything to assure that retarded juveniles will receive minimally adequate education and training in the least restrictive setting, particularly in view of the limited availability of such facilities.

The procedures mandated by the majority requiring a probable cause and full commitment hearing with the appointment of counsel go beyond the due process requirements of our law and is not in the best interests of the retarded juvenile whose sole need is for education, training and care. The majority opinion sets forth several reasons for mandating a probable cause and a full commitment hearing together with the appointment of counsel. One reason given is that there may be instances in which the parents' interests will be in conflict with the child's right to minimally adequate education and training. There may be instances where this is so, but the overwhelming majority of parents are committed to obtaining an habilitation program which will improve the level of functioning of their retarded child. Furthermore, the Act and regulations under the Act make it impossible for the parents acting alone to have their retarded child admitted to a mental health facility. The regulations make it necessary that the retarded juvenile be referred to the mental health facility by a mental health professional, pediatrician, general physician, or psychologist, and that the referral must include a psychiatric, medical or psychological evaluation setting forth what is needed by the retarded child. The regulations also require the Director of the mental health facility to conduct an independent

examination of the retarded child and if he or she does not agree with the opinion of the professional recommending the referral, the retarded child must be discharged from the facility immediately. I do not share the concern of the majority that the irresponsibility of a few parents provides sufficient reason for declaring unconstitutional these statutes which establish a voluntary procedure whereby parents acting in concert with the professionals in the field of retardation, together with the Director of the mental health facility, may obtain habilitation for a retarded child.

Another reason offered by the majority in support of its due process mandate is that a stigma attaches to a child who is classified "mentally retarded". There is no question that there are some who consider retardation to be a stigma. We are also aware that today a majority of our enlightened citizens recognize that mental retardation and mental and emotional illness should not be considered a stigma; handicap yes, stigma no. In any event, requiring the appointment of an attorney to represent the retarded juvenile and mandating a court proceeding will not alleviate the so-called stigma problem.

The majority also reasons that its due process order is necessary to protect juveniles who are not retarded from being admitted to a facility for the retarded. Such a juvenile would, of course, be the victim of an error by the professionals in the field. The mandated procedures will do little to eliminate such errors. I do not deny the wisdom of an appeal to the legal system when parties have a dispute. However, mandating a legal proceeding for the determination as to the kind of education, training and care which will be most beneficial to the retarded

juvenile is a decision more appropriately left to the professionals outside the judicial process.

We are here concerned with the procedures for the voluntary commitment and admission of the retarded juvenile to a facility providing minimally adequate habilitation in the least restrictive setting. The due process procedures mandated by the majority has, in effect, abolished the voluntary admission and commitment procedures for retarded juveniles, turning each admission into a court commitment procedure almost identical to the involuntary commitment procedure provided in §406 of the Act. The involuntary commitment procedure for juveniles, which has existed for many years, has certainly not eliminated nor alleviated those problems—irresponsible parents, stigma, errors in diagnosis, inadequate habilitation in restrictive facilities—upon which the majority bases its reasoning for declaring unconstitutional the voluntary admission and commitment procedures for retarded juveniles.

Mental Health Procedures Act of 1976, 50 P.S. §§7101-7503 (Supp. 1978-79).

The Mental Health and Procedures Act of 1976 has drastically changed the statutory scheme dealing with the mentally and emotionally distressed from that which was presented to this Court during the *Bartley* case. As a result of the new Act, we are presented solely with the due process claims of mentally and emotionally ill juveniles under the age of fourteen. Those mentally and emotionally distressed juveniles fourteen years of age and older, for purposes of the Act, are treated substantially the same as adults.

The Act provides that a parent, guardian or person standing in loco parentis to a child less than fourteen

years of age may subject the child to examination and treatment under the Act. §201. Upon acceptance for voluntary examination and treatment, the Act provides that the individual "shall be given a physical examination. Within 72 hours after acceptance . . . an individualized treatment plan[3] shall be formulated by a treatment team[4]. . . . The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions." §205.

A person under the age of fourteen may withdraw from the facility upon application of his or her parent, guardian or person standing in loco parentis. Additionally, "any responsible party" who believes that it would be in the best interests of the child to be withdrawn from

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[3] "'*Treatment plan*' means an individualized plan of treatment formulated for a particular person in a program appropriate to his or her specific needs, and to the extent possible, made with the cooperation, understanding and consent of the person in treatment, and imposing the least restrictive alternative consistent with affording the person adequate treatment for his or her condition, on forms developed by facility and approved by Department." Regulations implementing 1976 Act, §7100.1.2, 6 *Pennsylvania Bulletin*, 2115, 2116 (1976).

[4] "'*Treatment team*' means an interdisciplinary team of at least three persons appointed by the facility director, composed of mental health professionals and others. At least one member of the team shall be a physician. The treatment team shall formulate and review an individualized treatment plan for every person who is in treatment under this Act. The treatment team shall consult with appropriate persons regarding the inclusion in the treatment plan of specific modalities not within the training and experience of the members of the treatment team." §7100.1.2, 6 *Pennsylvania Bulletin*, 2115, 2116 (1976).

inpatient treatment or afforded treatment constituting a less restrictive alternative may petition the Juvenile Division of the court of common pleas for the county in which the child resides and request withdrawal or modification of treatment. The Act provides that once a petition is filed, the court must appoint counsel for the child and schedule a hearing within ten days to "determine what inpatient treatment, if any, is in the minor's best interest." §206(b).

The regulations promulgated pursuant to the 1976 Act give further procedural protections to the mentally or emotionally disturbed child under the age of fourteen. They provide that each individual shall be re-examined and his or her treatment plan reviewed not less than once every 30 days, and that on the basis of the re-examination and review the treatment team must either authorize continuation of the existing treatment plan, if appropriate, formulate a new individualized treatment plan, or recommend to the director the discharge of the juvenile. The regulations specifically provide that the child "shall not remain in treatment or under any particular mode of treatment for longer than such treatment is necessary and appropriate to his or her needs." §7100.1.6.3.C.

The regulations also provide for a "clearly defined" appeal system whereby any patient who wishes to voice objections concerning his or her treatment shall be heard, and shall have his or her treatment plan reviewed by a mental health professional independent of the treatment team who shall make a report of his or her review to the director of the facility. §7100.1.6.4.

Finally, the regulations establish a "Patient Bill of Rights" which is to be given to the child upon admission

to the facility, and is to be posted in each resident's living unit and treatment area. When the individual is unable to read, the regulations provide that the Bill of Rights is to be read and explained to the patient. Attached to the Bill of Rights are the names, addresses and telephone numbers of legal and other available advocacy services. The Bill of Rights provides:

YOU HAVE A RIGHT TO BE TREATED WITH DIGNITY AND RESPECT

YOU SHALL RETAIN ALL CIVIL RIGHTS THAT HAVE NOT BEEN SPECIFICALLY CURTAILED BY ORDER OF COURT

1. You have the right to unrestricted and private communication inside and outside this facility including the following rights:

a. To peaceful assembly and to join with other patients. To participate in or organize a body of patient government when patient government has been determined to be feasible by the facility.

b. To be assisted by any advocate of your choice in the assertion of your rights and to see a lawyer in private at any time.

c. To make complaints and to have your complaints heard and decided promptly.

d. To receive visitors of your own choice at reasonable hours unless your treatment team has determined in advance that a visitor or visitors would seriously interfere with your or others treatment or welfare.

e. To receive and send unopened letters and to have outgoing letters stamped and mailed. In-

coming mail may be examined for good reason in your presence for contraband. Contraband means specific property which entails a threat to your health and welfare or to the hospital community.

f. To have access to telephones designated for patient use.

2. You have the right to practice the religion of your choice or to abstain from religious practices.

3. You have the right to keep and to use personal possessions, unless it has been determined that specific personal property is contraband. The reasons for imposing any limitation and its scope must be clearly defined, recorded and explained to you. You have the right to sell any personal article you make and keep the proceeds from its sale.

4. You have the right to handle your personal affairs including making contracts, holding a driver's license or professional license, marrying or obtaining a divorce and writing a will.

5. You have the right to participate in the development and review of your treatment plan.

6. You have the right to receive treatment in the least restrictive setting within the facility necessary to accomplish the treatment goals.

7. You have the right to be discharged from the facility as soon as you no longer need care and treatment.

8. You have the right not to be subjected to any harsh or unusual treatment.

9. If you have been involuntarily committed in accordance with civil court proceedings, and you

are not receiving treatment, and you are not dangerous to yourself or others, and you can survive safely in the community, you have the right to be discharged from the facility.

10. You have a right to be paid for any work you do which benefits the operation and maintenance of the facility in accordance with existing Federal Wage and Hour Regulations.

The 1976 Act and its accompanying regulations, including the Bill of Rights quoted above, provide sufficient due process protections to a mentally or emotionally ill juvenile under the age of fourteen. They provide that within 72 hours after admission, the mentally or emotionally ill child will be examined and a treatment plan formulated, the primary purpose of which is to determine what treatment, if any, is appropriate for the child. It provides for re-examinations of the juvenile and a review of his or her treatment plan at least every 30 days. An internal appeal mechanism is created whereby the juvenile may challenge the modalities of his or her treatment. A "Bill of Rights" has been drafted and circulated to insure that those admitted to mental health facilities are aware of their constitutional rights, and of mechanisms available to secure any rights which might be infringed. Finally, the Act provides that "any responsible party" who believes that it would be in the best interests of the child to be withdrawn from inpatient treatment or afforded treatment constituting a less restrictive alternative, may petition the court of common pleas and request withdrawal or modification of treatment. Once such a petition is filed, the court must appoint counsel and schedule a hearing within 10 days to "determine what inpatient treatment, if any, is in the minor's best interest."

Due process does not require a full judicial hearing in every conceivable case of governmental impairment of private interest. *Board of Curators of the University of Missouri v. Horowitz,* U.S. , 98 S.Ct. 948, 952 (1978); *Stanley v. Illinois,* 405 U.S. 645, 650 (1972). "[T]he very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation." *Board of Curators of the University of Missouri v. Horowitz,* 98 S.Ct. at 953.

As justification for the procedures which its order mandates, the majority stresses the potential for conflict between parent and child; the risks of misdiagnosis and stigma. As to the potential of conflict between a parent and child, the comments heretofore made in the discussion concerning retarded juveniles are equally applicable to mentally and emotionally ill juveniles. In addition, the due process procedure mandated by the majority, setting up, as it does, an adversary court proceeding, may discharge parents from seeking treatment for a child suffering a mental or emotional illness. These due process procedures might retard the progress which has been made encouraging parents to seek early treatment for a mentally ill or emotionally disturbed child. The comments made with respect to the risks of misdiagnosis and stigma, heretofore discussed in connection with mentally retarded juveniles, are likewise applicable. The possibility of a misdiagnosis and the fact that some people still consider mental and emotional illness a stigma should not subject all juveniles to the elaborate due process procedures ordered by the majority in today's enlightened society which has at last begun to recognize that mental and emotional illness is not a stigma to either the parents or child and should be considered and treated on the same basis as society accepts

and treats physical illness, i.e., with compassion and understanding. Moreover, as stated in connection with the mentally retarded, it is difficult to perceive how the procedures mandated by the majority will mitigate or eradicate the alleged conflicts between parent and child, misdiagnosis and the alleged stigma attached to the mental and emotional problems of juveniles.

As stated in the *Bartley* dissent, the majority has prescribed "an overdose" of due process which in effect abolishes the voluntary admission and commitment procedures for mentally and emotionally ill juveniles under fourteen years of age and for all retarded juveniles.

(s) Raymond J. Broderick
Raymond J. Broderick, *J.*

Supreme Court, U. S.
FILED
AUG 8 1978
MICHAEL RODAK, JR., CLERK

In the Supreme Court of the United States

No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania.

BRIEF FOR APPELLANTS

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* Appellants examined in excess of seventeen (17) state statutes similar to those brought into question in this case which are cited at p. 24, infra.

50 Pa. Stat. Ann. §7301 21
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3 Pa Bull. 1840 .....9, 10, 11

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OPINIONS BELOW

The original majority and dissenting opinions of the District Court are reported at 402 F. Supp. 1039 and are set forth in the appendix at (783a-823a). The decision of the majority and dissent, not yet reported, are set forth in the appendix at (1051a-1115a).

JURISDICTION

The decision of the District Court and its final order were entered on May 25, 1978 (1051a). This appeal was docketed on May 31, 1978 and probable jurisdiction noted on June 19, 1978. The jurisdiction of this Court is conferred by Title 28 U.S.C., Section 1253.

STATUTES AND REGULATIONS INVOLVED

Statutes

Mental Health and Mental Retardation Act of 1966, 50 P.S. §4402 et seq.

§4402. Voluntary admission; application, examination and acceptance; duration of admission

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application for admission has been made under the provisions of section 402 (a) (2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of section 402 (a) (2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

(d) Each admission under the provisions of this section shall be reviewed at least annually by a committee, appointed by the director from the professional staff of the facility wherein the person is admitted, to determine whether continued care is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation may permit.

Where the admission is under the provisions of section 402 (a) (2), the person admitted shall be informed at least each sixty days of the voluntary nature of his status at the facility.

§4403. Voluntary commitment; application, examination and acceptance; duration of commitment

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

(d) Each commitment under the provisions of this section shall be reviewed at least annually by a committee, appointed by the director from the professional staff of the facility wherein the person is cared for, to determine whether continued care and commitment is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation shall permit.

Where the commitment is under the provisions of section 403 (a) (2), the person committed shall be informed at least each sixty days of the voluntary nature of his status at the facility.

§4426. Habeas corpus; discharge by order of court

(a) Every person committed or detained in a facility by reason of the provisions of this act or anyone acting on his behalf, may at any time, petition for a writ of Habeas Corpus and, except as hereinafter provided, said petition shall be filed in accordance with the provisions of the act of May 25, 1951 (P.L. 415).

(b) Said petition may be based upon the following grounds:

(1) The insufficiency or illegality of the proceedings leading to such person's commitment, or,

(2) Although the commitment proceedings were proper, such person's continued detention or hospitalization is not warranted by reason of mental disability. Where the petition is based on this ground: (i) it shall be accompanied by the affidavit of a physician stating that he has examined the person and is of the opinion that such person is not mentally disabled, or that such mental disability does not require care or treatment in a facility, and (ii) the burden of proof shall rest upon the director responsible for such person's continued detention.

(c) Jurisdiction and venue is hereby conferred upon the several courts of the Commonwealth to issue writs of Habeas Corpus filed under this act as follows:

(1) A petition filed under section 426 (b) (1) may be filed: (i) where committed by a court, only in the same court, or (ii) where committed under sections 404 or 405 of this act, only in the court of the county where the application for commitment was made.

(2) A petition filed under section 426 (b) (2) may be filed: (i) in the court which committed such person or the court of common pleas of the county where he is detained if a civil commitment was ordered, or (ii) where a criminal charge is pending, in the court having jurisdiction of the charge or which committed him or the court of the county where he is detained, or (iii) where committed by a court where a criminal act was in any way otherwise involved in the proceedings leading to commitment, only in the same court which committed such person.

(3) If any petition under section 426 (b) (2) is filed in a court other than the court of the county in which the person is detained, the petition may be transferred for disposition by the court in which it was filed to the appropriate court of the county in which the person is detained.

Mental Health Procedures Act of 1976

§7201. Persons who may authorize voluntary treatment

Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

1976, July 9, P.L. 817, No. 143, §201, effective in 60 days.

§7205. Physical examination and formulation of individualized treatment plan

Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment plan shall be formulated by

a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

1976, July 9, P.L. 817, No. 143, §205, effective in 60 days.

§7206. Withdrawal from voluntary inpatient treatment

(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203.1 he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may effect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in

accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commission of Mental Health or his designate.

1976, July 9, P.L. 817, No. 143, §206, effective in 60 days.

Regulations

Volume 3, Pennsylvania Bulletin, p. 1840 Department of Public Welfare

Additional Procedural Safeguards for Juveniles Admitted to Institutions

The Department of Public Welfare by this Order adopts additional procedural safeguards for juveniles admitted to institutions pursuant to §402 and §403 of the Mental Health and Mental Retardation Act.

Notice of the proposed rule making was published in 3 Pa. B. 536, March 24, 1973.

After consideration of the views presented by interested persons, the regulations are adopted with some changes. Additions have been made in Paragraphs 1, 2, 6, 7 and the form of notification to permit referral of mentally retarded juveniles to institutions by either a pedia-

trician, or general physician or psychologist. A new paragraph has been written to reflect whether the juvenile is capable of understanding the notification form. In these regulations, the word "applicant" shall refer to the person who signed the juvenile in while the word "juvenile" shall refer to any youth 18 years of age or younger. Several comments urge that the role of the Public Defendant's Office be replaced by a legal service program; however, the Public Defender Act, December 2, 1968 P.L. 1144, (No. 358) §1 *et seq.*, (16 P.S. 9960.6(a), (c), specifically makes the Public Defender responsible for persons who are or may be subject to commitment under the Mental Health and Mental Retardation Act of 1966. To the extent, however, that Legal Services other than the Public Defender are readily available, such Legal Services may be utilized in lieu of the Public Defender's Office and §5, §6 and §9 of these regulations have been changed accordingly. These regulations shall not be interpreted to permit direct intake into state-operated facilities. Although the Department is adopting these regulations, it will evaluate the procedures at the end of six months. If necessary the Department will at that time hold public hearings.

The regulations hereby adopted are adopted pursuant to Article 2, §201 of the Mental Health and Mental Retardation Act of 1966, Act of October 20, 1966, No. 6, Third Special Session.

The Department of Public Welfare finds:

1. That public notice of intention to adopt the administrative regulations adopted by this Order has been duly given pursuant to §§201 and 202 of the Commonwealth Documents Law (45 P.S. §§1201 and 1202) and the regulations thereunder, 1 Pa. Code §§7.1 and 7.2.

2. That the adoption of the regulations in the manner provided in this Order is necessary and appropriate for the administration of the Mental Health and Mental Retardation Act of 1966.

The Department of Public Welfare, acting pursuant to the Public Welfare Code, and the Mental Health/Mental Retardation Act of 1966, orders:

(A) The regulations of the Department of Public Welfare are amended to read as set forth in Annex A to this order.

(B) The Secretary of the Department of Public Welfare shall submit this Order and Annex A hereto to the Department of Justice for approval as to legality as required by law.

(C) The Secretary of the Department of Public Welfare shall duly certify this Order and Annex A hereto and deposit same in the Legislative Reference Bureau as required by law.

(D) This order shall take effect upon publication.

(s) _____

Secretary of Public Welfare

ANNEX A

Rules Relating to Persons 18 Years of Age or Younger Admitted to Mental Health or Mental Retardation Institutions Pursuant to §§402 and 403 of the Mental Health and Mental Retardation Act

1. All juveniles aged 18 and younger to be admitted to an Institution must be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist.

2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;

3. The Director of the Institution or his delegate, shall have conducted an *independent* examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate, shall discharge the juvenile;

4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;

5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that

he can call for representation. An appropriate person shall explain this notice (attached);

6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, *if he feels it is necessary for the youth to remain,* may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director or, his delegate, shall notify the Public Defender's Office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two day period, the juvenile shall remain institutionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service Unit to file a 406 proceeding within two days after failure to locate the applicant;

7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile.

8. If the staff members of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification;

9. Juveniles aged 13 and older shall be given the following notice:

RIGHTS OF CHILDREN UNDER §402 and §403

You have currently been admitted to the———— ————Institution for observation and treatment. This voluntary admission procedure was instituted by ———— on ———— (date). You can call the applicant at Telephone Number ———— ———— or you can write the applicant at ———— ————. The purpose in having you admitted to this facility is to help you overcome problems you are experiencing and to return you to the community as soon as possible. Before we accepted you, you must realize that a (circle which one) psychiatric, medical, or psychological opinion was given to us by ————. Also, the Director of this Institution had a (circle which one) psychiatric, medical, or psychological examination conducted so that he could be thoroughly appraised and certain that you could benefit in receiving care and treatment at this Institution.

If you object to remaining in this Institution, you are advised that we shall contact the Public Defender's Office to make other suitable arrangements to obtain legal counsel for you. We will provide you with the telephone number of the attorney who has been contacted on your behalf. We will require two working days from date of your objection to remain, in order to make certain that you will be afforded counsel. At the same time, the Director, or his delegate, of this Institution shall notify the applicant of his desire to require you (sic) hospitalization for your benefit.

A member of our staff shall explain this written letter to you and we ask you to sign it, which will evidence that you have a copy of this letter and that it has been

explained to you in detail. In the event that you have any questions, you can direct them to the person who is explaining this document to you or you may contact this office.

————————

Superintendent's Signature

————————

Patient's Signature

————————

Staff Member's Signature
Giving Notice to Patient

QUESTIONS PRESENTED

I. Whether the Due Process Clause of the Fourteenth Amendment is implicated when a parent admits his child for medically-recommended in-patient mental health or retardation treatment?

II. Whether the admissions of children to private mental health or mental retardation facilities constitute state action for purposes of the Fourteenth Amendment?

III. Whether the District Court erred in its certification of the Plaintiff and Defendant Classes?

IV. Whether retroactive aspects of the lower Court's order are proper?

STATEMENT OF THE CASE

A. History of the Proceedings:

In 1971 and 1972 each of the original plaintiffs were admitted to Haverford State Hospital for in-patient psychiatric therapy.[1] Each of these admissions was effectuated by the child's parent or parents acting in concert with a physician, pursuant to Section 4402 or 4403 of Pennsylvania's Mental Health and Mental Retardation Act of 1966 (the "1966 Act"). According to the terms of that statute, they each received a complete psychiatric examination prior to his admission to determine whether or not such treatment was necessary.

Pennsylvania law, however, did not require that children be provided an adversarial hearing where, with the assistance of counsel, they could challenge the wisdom or medical basis for seeking inpatient therapy. Accordingly, this lawsuit was commenced on November 16, 1972, challenging the constitutionality of this statute on due process grounds (23a). On behalf of a class,[2] they

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[1] The original plaintiffs, Kevin Bartley, Steve Gentile, Leslie Levine, Vicki Mathews, and Mark Weand were juveniles afflicted with mental illness as opposed to mental retardation.

[2] Originally the plaintiff class was composed of: "all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act (Act)." Moreover, the court specifically noted that this description was intended to encompass both emotionally ill and mentally retarded children (783).

sued the superintendent of the hospital as well as various officials of the Pennsylvania Department of Public Welfare seeking a broad array of injunctive relief including a pre-admission adversarial hearing with the right of counsel. The plaintiffs focused only upon what they perceived to be an unconstitutional admission procedure,[3]—asserting no claim, nor offering any evidence whatsoever that their care was inadequate or inappropriate.

Because the questions involved were substantial, and in view of the injunctive relief requested, a three-judge court was convened pursuant to 28 U.S.C. §2281. Finding the statute unconstitutional on Due Process grounds, a majority of the district court entered an injunction requiring that the defendants provide; (1) a "probable cause hearing" within seventy-two hours of hospitalization (defendants were required to serve prior written notice of that hearing upon the child and his attorney at least forty-eight hours beforehand); (2) a "post-commitment hearing" within two weeks of hospitalization (with a similar prior notice requirement); (3) "Counsel at all significant stages of the commitment," (4) the right to

[3] Shortly after this lawsuit was commenced the Pennsylvania Department of Public Welfare promulgated regulations augmenting Sections 402 and 403 as they pertained to juveniles (supra). These regulations greatly expanded the procedural protections afforded juveniles. Briefly, they require not one, but two independent psychiatric or psychological examinations prior to admission, each indicating the necessity for hospitalization. In addition, each child thirteen years of age or older receives written notice of all his rights under the regulations including the right to be provided free counsel, and the right to a hearing upon objection in any manner whatsoever to the continued inpatient therapy.

be present at all hearings and to confront and cross-examine witnesses as well as to present testimony on their own behalf. And finally, the Court ordered that, within 120 days, each of the thousands of children then hospitalized in mental health facilities throughout Pennsylvania either be discharged or recommitted in accord with the newly mandated procedures (843a-852a).

An appeal was taken to this Court and probable jurisdiction noted. However, while that appeal was pending the Pennsylvania legislature enacted the Mental Health Procedures Act[4] which repealed the challenged statutes only insofar as they applied to mentally ill children. After argument, this Court vacated the district court's opinion and remanded the case for further consideration in light of the changed circumstances occasioned by this new legislation. *Kremens v. Bartley*, 431 U.S. 119 (1976).

On remand the plaintiffs amended and supplemented their complaint adding representative plaintiffs, and a proposed class of defendants.[5] However, they did not alter the theory of their claim, premising their challenge to both the 1966 and 1976 Acts on the Due Process Clause of the Fourteenth Amendment.

[4] 50 Pa. Stat. Ann. §7101 *et seq.* (hereafter referred to as the "1976 Act").

[5] The plaintiffs sought and the district court certified a defendant class composed of:

> The directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare (956a).

As will be discussed later, this class includes the directors of private facilities, community-based group homes and mental health centers, as well as private schools "approved" to dispense mental health or retardation therapy.

On May 25, 1978, the district court entered its decision, once again declaring the challenged statutes unconstitutional, and enjoining their enforcement. Specifically, the district court again ordered that every child admitted by his parents to a mental health facility, whether public or private, be provided two separate adversary hearings commencing no later than three days after the admission. The hearings remained exactly as originally ordered—one to determine "probable cause", of the illness or retardation and the other to establish the medical need for in-patient treatment. In addition to these hearings, the children were again provided the rights of prior notice, free counsel,[6] as well as confrontation and cross-examination of adverse witnesses. Finally, all children presently receiving treatment in any of the hundreds of facilities in Pennsylvania were ordered to be either discharged or readmitted pursuant to those procedures within one hundred and eighty days. Shortly after the District Court's Order was entered, this appeal was initated, seeking review of both the declaratory and injunctive aspects of the order.

B. The Admission Process: An Overview

Under the 1966 Act, which only applies to the mentally retarded, there are three general means by which one may be admitted to in-patient residential care: voluntary (§402 and §403), emergency (§405), and involuntary

[6] The Order refers to a "trained representative" as an acceptable alternative to counsel. However in the context of all of the mandatory formalities of the hearings established by the District Court, it is difficult to imagine how a non-lawyer could effectuate and protect all of the rights provided to the children, such as confrontation and cross-examination.

(§406). The first, voluntary admission, is the focus of this litigation. Under these provisions only persons eighteen and over may voluntarily admit themselves for necessary examination and care. Children, on the other hand, must be admitted and for that matter, withdrawn by their parents or guardians, 50 Pa. Stat. Ann. §4402 and §4403.

Similarly, under the 1976 Act, which applies to the mentally ill, there are three parallel procedures: voluntary (§7201), involuntary (§7301), and emergency (§7302). Again it is the voluntary procedure which is under attack here, because it distinguishes between adults and children by allowing parents or guardians to voluntarily admit their children for inpatient treatment.[7] Appellees contend that these procedures violate the mandate of the Due Process Clause by, in effect, allowing their parents to involuntarily admit them for needed medical and psychological treatment without the full panoply of traditional Fourtheenth Amendment procedural protections, *viz.*, prior notice, counsel, and adversary hearing.

Several other features of the Pennsylvania system of mental health admissions bear noting. First, any person committed to a mental health facility may test the validity of his custody by petitioning for a writ of habeas corpus in state court. 50 Pa. Stat. Ann. §4426; 50 Pa. Stat. Ann. §7206. Moreover, a patient may demand an independent psychiatric evaluation to assure the accuracy of the diagnosis and recommendation for his admission to the facility. E.g., 50 Pa. Stat. Ann. §4423-(7). Additionally, the director of any facility must discharge any

[7] Under the 1976 Act the age of majority is fourteen, contrasted with eighteen under the 1966 Act.

patient when that patient no longer needs care and treatment in the facility. 50 Pa. Stat. Ann. §4418, §4420, §7206(c).

Finally, the Pennsylvania Department of Public Welfare promulgated regulations under both Acts. These regulations augment Sections 4402 and 4403 of the 1966 Act, and Section 7201 of the 1976 Act as they apply to juveniles. Although the general effects of these regulations have already been highlighted, it is important to examine all of these provisions more closely at this point. Parts 2 and 3 of the regulation under the 1966 Act guarantee that no juvenile may be admitted to a Pennsylvania retardation facility unless two independent psychiatric examinations reveal that admission is necessary and appropriate. If the results of these examinations do not agree on the need for hospitalization, the child may not be admitted. Additionally within 24 hours of admission, every child over 13 years of age must be given oral and written notice of his rights, including the right to receive periodic reports of his condition, the right to privately communicate with family and counsel, and, if necessary, the right to be furnished counsel. If a juvenile over thirteen years of age objects to continued treatment in the institution, counsel is immediately notified, as are all other interested parties. At this point, the child's hospitalization may continue for a maximum of two business days during which appropriate proceedings must be commenced under Section 4406 of the Act, or the child must be discharged.[8]

[8] There is a possibility of a slightly extended institutionalization in the situation where the director of the facility involved cannot locate the applicant (parent or guardian) and continued hospitalization is recommended. In this case an involuntary civil commitment (§4406) is then instituted by the appropriate local mental health referral and treatment agency.

Similarly, under the 1976 Act a complete medical examination indicating the need for in-patient therapy is required before the admission may occur. Children admitted under this Act are also given notice of a broad array of substantive rights which they have been guaranteed by regulations promulgated under the Act. *See, e.g.*, "Bill of Rights", 6 Pa. Bull. 2119 §7100.1 10.3 (Sept. 4, 1976); 7 Pa. Bull. 1848 (July 2, 1977). In addition to rights of advocacy and grievance, all patients have the right to be discharged when they no longer need treatment, not to mention the statutory right to judicially challenge the validity of the admission at any time. 50 Pa. Stat. Ann. §7206.

This then is the general statutory and regulatory framework within which children may be admitted or committed to mental health facilities in Pennsylvania. It is indeed an understatement to note that there are substantial legal and practical impediments confronting parents intent on "dumping" a child in a Pennsylvania mental health facility, not the least of which is simply the scarcity of available beds.[9] In fact, Pennsylvania compares very favorably with most of her sister states in this regard. Appellants' examination of similar state statutes reveals that Pennsylvania's pre- and post-admission standards and procedures for juveniles, in terms of safe-

[9] Pennhurst Center for example has almost twice as many persons on its waiting list for admission than are actually in the facility receiving care.

guarding the interests of the child, equal or exceed those provided in most, if not all, of those states.[10]

[10] Statutes reviewed: 1976 Haw. Sess. Laws, Act 130 §334; Idaho Code Ann. §66-318, 66-320; Ky. Rev. Stat. §202A.020; Mass. Gen. Laws. Ann. ch. 123, §10, 11; Mo. Ann. Stat. §202.783, 202-.790 (Vernon); Nev. Rev. Stat. §433A.140, 433A.560; N.H. Rev. Stat. Ann. §135-B:11; N.J. Stat. Ann. §30:4-46, 30:4-48 (West); N.Y. Mental Hyg. Law §9.13; Okla. Stat. Ann. tit. 43A, §184 (West); Or. Rev. Stat. §426.220; Tenn. Code Ann. §33-601; Utah Code Ann. §64-7-29; Vt. Stat. Ann. tit. 18, §8807; Wis. Stat. Ann. §51.10 (West); Wyo. Stat. §25-3-106.

SUMMARY OF ARGUMENT

I. When a parent seek's medically recommended inpatient therapy for his child, no constitutionally protected liberty interest of the child is affected. Although there are limits to the autonomy that a parent enjoys from governmental interference in matters of child-rearing, they are not involved here. Inasmuch as there is absolutely no evidence of parental or professional irresponsibility here, there simply is no basis for displacing the traditionally recognized authority of parents and physicians to provide for the health needs of children. Parents, in conjunction with their physician, must not only be involved in these grave decisions, but they must be in control, absent the most compelling of circumstances. Even if, contrary to the evidence, we assume that parents and physicians occasionally conspire to remove a child from his home, the procedures mandated by the lower court will have little, if any curative effect in those cases.

Finally, as the record in this case clearly demonstrates, admissions to Pennsylvania facilities follow a very careful evaluation and diagnostic process. In fact, each of the named plaintiffs received several independent medical examinations and psychological evaluations prior to admission each of which concurred in the need for inpatient care. The procedures used in Pennsylvania are simply not deficient for Due Process purposes.

II. Admissions of a child to private facilities does not constitute 'State action' for purposes of the Due Process Clause. Pennsylvania plays no role in these admis-

sions except to license the facility to operate. The state's facilities, employees, or, in most cases, funds are not involved whatsoever.

III. The plaintiff and the defendant classes certified by the district court do not comport with the requirements of Rule 23(a) Fed. R. Civ. Pro. Both classes are permeated with a lack of homogeneity. In each class there are significant subgroups that have interests quite different from the class representatives, which interests were not, and could not have been represented by the named plaintiffs.

IV. The lower court's order for retroactive implementation violates the principles of federalism recognized by this Court in *Preiser v. Rodriguez,* 411 U.S. 475 (1973). Clearly, the plaintiffs in this case had the complete remedy of habeas corpus available to them, and at the very least, they should not have been permitted to attack the legality of their custody by the means of this civil rights action.

ARGUMENT

I. THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT IS NOT IMPLICATED WHEN A PARENT ADMITS HIS CHILD FOR MEDICALLY RECOMMENDED IN-PATIENT MENTAL HEALTH OR RETARDATION TREATMENT

A. Liberty Interest of the Child:

The relationship between parents and their children is deserving of, and has received special protection from this Court. Governmental intrusion upon the parental right to supervise and direct the upbringing of their offspring has not lightly been countenanced by this Court. Thus in *Stanley v. Illinois,* 405 U.S. 645 at 651 (1972), it was noted that:

> The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed 'essential,' Meyer v. Nebraska, 262 U.S. 390, 399 (1923), 'basic civil rights of man,' Skinner v. Oklahoma, 316 U.S. 535, 541 (1942), and '[r]ights far more precious . . . than property rights,' May v. Anderson, 345 U.S. 528, 533 (1953). 'It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.' Prince v. Massachusetts, 321 U.S. 158, 166 (1944). The integrity of the

family unit has found protection in the Due Process Clause of the Fourteenth Amendment, Meyer v. Nebraska, supra, at 399, the Equal Protection Clause of the Fourteenth Amendment, Skinner v. Oklahoma, supra, at 541, and the Ninth Amendment, Griswold v. Connecticut, 381 U.S. 479, 496 (1965) (Goldberg, J., concurring).

In short, the sanctity of this parental responsibility, as well as freedom, to direct the upbringing of their children is ". . . established beyond debate as an enduring American tradition". *Wisconsin v. Yoder,* 406 U.S. 205, 232 (1972).

This parent-child relationship is, of course, the touchstone of the notion of a family's right of privacy under the Constitution. In *Roe v. Wade,* 410 U.S. 113 at 152-3 (1972), Mr. Justice Blackmun pointed out that:

> [The] decisions make it clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty', Palko v. Connecticut, 302 U.S. 319, 325 (1937), are included in this guarantee of personal privacy. They also make it clear that the right has some extension to activities relating to marriage, Loving v. Virginia, 388 U.S. 1, 12 (1967); procreation, Skinner v. Oklahoma, 316 U.S. 535, 541-542 (1942); contraception, Eisenstadt v. Baird, 405 U.S. at 453-454; id. at 460, 463-465 (White, J., concurring in result); family relationships, Prince v. Massachusetts, 321 U.S. 158, 166 (1944); and child rearing and education; Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925); Meyer v. Nebraska, [262 U.S. 390 (1922)]. 410 U.S. 113, 152-3 (1972).

This Court has been steadfast in this view, and only last term admonished against governmental intrusion into the ". . . private realm of family life which the state cannot enter." *Moore v. East Cleveland,* 431 U.S. 494, 97 S. Ct. 1932 (1977). Thus, for example, in *Wisconsin v. Yoder, supra,* the state's admittedly compelling interest in educating its youth was subordinated to the parents' contrary wishes.

Of course, there are reasonable limitations on the autonomy of parents in the supervision of their children. For example, one of the highest duties of parenthood is providing for the health needs of one's children. Nevertheless, in life threatening situations, courts, at times have reluctantly superseded the parents.* However, in other situations parental wishes concerning grave medical decisions for their children have not been disturbed in favor of the desires of well-intentioned public officials, *e.g. In the Matter of Quinlan,* 70 N.J. 10, 355 A.2d 647 (1976). Generally, it is only when parents abdicate their responsibility to safeguard their child's health in a life-threatening manner that the state will be permitted to involve itself. *In Re Green,* 448 Pa. 338, 292 A.2d 387 (1972); *In Re Sieferth,* 309 N.Y. 80, 127 N.E. 2d 820 (1955); *cf. Bykofsky v. Middletown,* 401 F. Supp. 1242 (M.D. Pa. 1975). The point is simply that courts will not, and should not, lightly allow governmental intrusions into any aspect of a family's privacy.[11]

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* See generally—Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy,* 86 Yale L.J. 645, 651-661 (March 1977).

[11] Noting that "nothing, not even magic, can qualify a judge to make [non-life or death medical decisions] with equal or greater accuracy than the parent," Professor Goldstein strongly criticized

In this case each of the appellees' parents sought medical help for what they perceived to be mental illness or retardation. Ultimately, in each case medical experts recommended residential treatment for the appellees. Each of the parents decided to follow this medical advice, and thereafter the children were, at various times, admitted to residential treatment facilities.[12] Without questioning the propriety of this decision, or even objecting to the treatment they were receiving, this lawsuit was instituted on the children's behalf by their guardian.[13]

The Appellees claimed, and the lower court found, that when their parents and physicians jointly decided that residential psychiatric therapy was in their best interest, they were unconstitutionally deprived of their 'liberty' under the Due Process Clause of the Fourteenth Amendment. Their theory is not complex: because they cannot come and go as they please, against the wishes of their parents and physicians, they are involuntarily hospitalized; and involuntary commitment in a mental hospital without a prior hearing and the right to counsel is, in turn, a denial of liberty without due process of law. Their argument's simplicity, ignoring the complex issues which are involved, was unfortunately subscribed to *in*

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just such an intrusion in *In Re Sampson*, 65 Misc. 2d 658, 317 N.Y.S. 2d 641 (Fam. Ct. 1970), *aff'd* 377 App. Div. 2d 668, 323 N.Y.S. 2d 253 (1971), *aff'd* 29 N.Y. 2d 900, 278 N.E. 2d 918, 328 N.Y.S. 2d 686 (1972).

[12] Nine of the plaintiffs, each being mentally ill, were admitted to Haverford State Hospital. Two were admitted to Polk Institute for the retarded, and one was admitted to Pennhurst Center for the retarded. Each of these is a state-operated facility.

[13] Appellees' guardian, appointed for this litigation by the district court, is their attorney in this litigation, as well as serving in that dual capacity for the entire remainder of the class.

toto by the court below. However, as is the case with most simple solutions to complex issues, it is fraught with grave difficulties.

In ruling in favor of the original plaintiffs, the district court made essentially three findings. First, it determined that Pennsylvania's procedure for the voluntary admission of juveniles for residential mental health treatment implicated a liberty interest, possessed by all children which was protected by the Fourteenth Amendment (794a-796a). Next the court concluded that parents may not "waive" this right on behalf of their child (796a). And finally it determined that in every admission of a child to residential care, all of the traditional procedural protections recognized under the Fourteenth Amendment must be afforded (843a-852a). In short, there could no longer be any voluntary admissions of children to in-patient psychiatric care in Pennsylvania. Without any substantial modifications [14] this reasoning was merely reaffirmed on remand from this Court.

The district court predicated its finding of a liberty interest on two points. First, the court found that when the parents decide to accept medical recommendations that the child receive in-patient care and admit the child

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[14] In determining the process which was due, the requirements of counsel and a judicial hearing were somewhat modified on remand. A "trained representative" and "independent unbiased tribunal" were substituted. Nevertheless it is doubtful that the changes are really significant. For example, the trained representative must be able to present evidence and protect the child's rights to confront and cross-examine adverse witnesses. Similarly, the strictures placed upon the "independent unbiased tribunal" are such that Pennsylvania has no alternative but to resort to the courts (1057a).

for that purpose, ". . . the child is involuntarily removed from his home and familiar surroundings . . ." (794a). Secondly, the court found that such a hospital admission entails a severe stigma which may exceed even that which is associated with a criminal conviction (795a).

Both of the underpinnings for this threshold determination are seriously flawed. The conclusion that the appellees were "involuntarily" removed from their home ignores the central fact of this litigation—that they are children. Without exception, the experts in this case agreed with the seemingly common place notion that children, and certainly those of tender years, lack the developmental capacity to be entrusted with such important medical decisions.[15] Dr. Leon Eisenberg, Professor of Psychiatry at Harvard University, put it well when he commented that "[i]t strains the imagination to conceive of a ten year old child able to decide for himself or herself the wisdom of a psychiatric admission any more than of an appendectomy or a blood transfusion."[16]

Fortunately each of us, as youths, have from time to time been "victimized" by parents and doctors in

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[15] *See, e.g.*, Armstrong 86a; Sugar 367-8a, 411a, 421a, 435a, 437a-438a; Tashjian 652a; Miller 678a, 699; Masterson 722a.

[16] Eisenberg, *An Epidemic of Kew Gardens Syndrome: The Redefinition of Caring as Coercion*, International Symposium of the Thistletown Regional Center (September 1977)—to be published in *New Directions of Children's Mental Health*, Spectrum Publications (1978). The same point was recently made by the President of the Connecticut Council of Child Psychiatrists commenting on proposed legislation in that state which would have required hearings for all juvenile admissions for in-patient care. Futterman, *Bill No. 384—Civil Commitment of Mentally Ill Minors*, Academy of Child Psychiatry Newsletter (June 1978).

health matters. Against our wishes, we have all as children been subjected to necessary and at times uncomfortable medical treatment which may have appeared callously inflictive. Nevertheless, this is as it must be. In this country, an element of freedom is the right of a competent adult to accept or reject health services *Winters v. Miller,* 446 F.2d 65 (2d Cir. 1971), cert. denied 404 U.S. 985 (1971). Children on the other hand are not accorded this level of responsibility. Accordingly, it has been noted that none of the states have laws which compel a physically ill individual to be involuntarily hospitalized merely because he needs treatment to protect his own welfare. (Note: *Developments In the Law: Civil Commitment of the Mentally Ill,* 87 Harv. L.R. 1190, 1216 n. 84 (1974). Furthermore, no court has ever ordered a competent adult to accept such hospitalization and medical treatment solely for his own benefit. *Compare, Application of President and Directors of Georgetown College,* 331 F.2d 1000 (D.C. Cir. 1964), *Winters v. Miller, supra.* But the necessary counterpart to this freedom to refuse treatment is the responsibility to authorize or consent to treatment. And as noted above, this authority has traditionally been lodged exclusively with competent adults. *See, E.g., Bonner v. Moran,* 126 F.2d 121, 75 U.S. App. D.C. 156 (1941).

This curtailment of voluntary action by children is apparent in other areas as well: *e.g., Oregon v. Mitchell,* 400 U.S. 112 (1970) (voting); *Belloti v. Baird,* 428 U.S. 132 (1976) (termination of pregnancy); *Ginsberg v. New York,* 390 U.S. 629 (1968) (reading materials); *Prince v. Massachusetts,* 321 U.S. 158 (1944) (earning money). Nevertheless, in the district court's view, admission of a child for in-patient treatment or habilitation is

different. While no constitutionally protected liberty interest is implicated if a parent decides, upon medical advice, to authorize the most risky of surgical procedures for his child,—in the lower court's view such an interest is implicated for example, when a parent seeks to admit his child to a group home or community mental health center for in-patient care—be it only for several weeks.[17] Similarly, no one would suggest that a child's liberty is affected when his parents admit him to a military school to "straighten him out"—not so in the lower court's view if that school happens to be licensed or approved as a mental health facility.[18]

The reason for all of this is apparently the stigma which the district court perceived may be attendant with receiving mental health or retardation care (1076a-1077a). While no doubt there are those who still view mental affliction with fear and apprehension, great strides have been and continue to be made in this area. Nevertheless it is doubtful that the procedures ordered by the district court will in fact protect children from any stigma

[17] In Pennsylvania the range of mental health and retardation services covers the continuum from small family-like facilities, such as community based group homes and mental health centers, which serve only a few residents, to large state operated institutions. Admission to one is the same as the other for constitutional purposes under order in this case.

[18] For example, the Devereau Foundation operates private schools which are "approved" mental health and mental retardation facilities under Pennsylvania law. Nevertheless such facilities are far more akin to private schools than they are mental institutions—and in fact are viewed publicly as such. Nevertheless each of these students will now become a prospective mental health admission—but each will be given due process. In the words of Dr. Masterson we may well have provided each with his "civil rights at the cost of his human rights . . ." (723a).

that still lingers. First, it is doubtful, based upon the evidence, that the hearings will do much more than deter some people from receiving early medical intervention for a problem that will inevitably worsen. In other words, the whole procedure will be traumatizing, and may cause parents to avoid necessary care for their children altogether.[19] In addition the process which is intended to protect the child from stigma may indeed exacerbate it. One phychiatrist, describing a similar procedure which now exists in New Jersey, noted that:

> the children involved often react as if they have been disposed of through criminal channels. Children ask those who have attended court hearings, 'How many months did you get?' The children view themselves as being identified as criminals and in fact think that they themselves are criminals. One twelve-year-old in particular was quite terrified of going to court.[20]

In addition to this, it is doubtful that the procedures will accomplish very much in terms of avoiding erroneous admissions which may needlessly subject a child to such stigma.[21] First the available data tend to show that the independent factfinder rarely, if ever, disagrees with med-

[19] Armstrong 80a; Sugar 370a-71a; Tashjian 655a; Miller 688a; Masterson 723a, 728a.

[20] Perr, Irwin, M.D., J.D., *Minors and Institutionalization,* Society for Adolescent Psychiatry, Inc., Newsletter (January 1978).

[21] There is no contention here that the appellees were needlessly receiving care. In fact none has yet sought to terminate their therapy—although several have completed their treatment and been discharged.

ical recommendations.[22] Once again, describing a system similar to that which was imposed by the district court in Pennsylvania it was reported that:

> Children were transported for court hearings in the cold marble palaces of justice where their confused and angry parents found themselves under scrutiny and attack. Local attorneys found that their court-appointed activities, if perfunctorily performed, provided modest but reliable remuneration. Initially the attorneys knew little of the issues as did the judges and the complex procedures were in reality a costly and time-consuming ratification procedure.[23]

Furthermore, any stigma which still exists with respect to mental illness or retardation is a reaction to the affliction rather than to its treatment. These prejudices will not be eliminated, nor their injurious effects avoided, by interposing legal proceedings of questionable value as a precondition to that treatment. Thus, it is clear that, as in all other areas of medical treatment, children have no constitutionally protected "liberty" interest, independent of their parents, which is adversly affected when that

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[22] Wengler & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. of Health & Social Behavior 66, 68 (1969). Moreover, Dr. Barbara Armstrong, a psychiatrist at Haverford State Hospital, testified that in her experience at Haverford she had seen only one real error in a medical diagnosis for institutional treatment, *and that followed a complete judicial hearing* (95a-96a).

[23] Perr, *Minors and Institutionalization, supra* at 2. See also Meisel, Roth, *The Child's Right to Object to Hospitalization—Some Empirical Data*, 4:3 Journal of Psychiatry and Law, 377-392 (Fall 1976).

parent authorizes medically recommended residential mental health treatment.

B. Waiver by the Parents:

Having decided that the parents' actions in this case had affected a Constitutionally protected right to liberty possessed by their children, the district court then looked to whether or not such rights could be waived by the parents (796a). Notwithstanding the involvement of rudimentary traditions of parental autonomy in matters of child rearing, and presuming "that in most instances parents [act] in [their] child's best interests . . ." (797a), the district court nevertheless determined that a child's parents and physician may never be entrusted with the responsibility for obtaining necessary inpatient care for that child (797a). The singular basis for this conclusion was its speculation, without any evidence of parental or medical irresponsibility whatsoever, that parents "may at times be acting against the interests of their children" (798a).

In effect a presumption of child abuse or, at a minimum, parental irresponsibility, has been raised every time a parent and physician jointly decide that in-patient psychiatric treatment is medically necessary. This flies in the face not only of centuries of Western tradition and culture, but is also contrary to most of the expert testimony placed before the district court.[24] Dr. Eisenberg makes the point well:

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[24] *E.g.*, Sugar 381a, 418-420a; Kandler 554a; Ingall 591a; Miller 692a-693a. See also Futterman, *Bill No. 384—Civil Commitment of Minors, supra* at 11; Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy, Supra.*

> That a number of parents do abuse their children and may wish to be rid of them at all costs does not contravene the correctness of assuming good will as the starting point. The new doctrine stands the world on its head. In the effort to prevent the violation of some, it does violence to all.[25]

Admission of a child for mental health or retardation therapy is, and should be, a very serious matter. Without a doubt, the consequences of an erroneous decision in this regard may be profound. It is just this type of a difficult decision that must be left to the family and physician, with a minimum of bureaucratic interference. Parents must be intimately involved, indeed, in control of the situation. In grave matters such as these we must not be tempted to take the easy route, and allow the government to make the decision. To do so, and follow the "new doctrine" established by the district court would make ". . . bystanders of us all, bystanders who rationalize uninvolvement by pious murmers about freedom."[26]

Thus, as the foregoing attests, the entire rationale for the district court's finding of a constitutionally protected "liberty interest" is misconceived. Children are simply not adults, and the law should not treat them as such. Medical decisions, and especially those of the grave nature involved here, must be left to the family in consultation with their physician. While there are doubtlessly adverse consequences which attach to mental affliction, that alone is not sufficient to displace all parental decision-making authority in this area. In short, the lower court's approach is wrong and must be reversed.

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[25] Eisenberg, *An Epidemic of Kew Gardens Syndrome: The Redefinition of Caring as Coercion, supra* at 9.

[26] Eisenberg, *Id. supra* at 10.

C. The Process Due:

After determining that the admission of a child for in-patient care did involve an aspect of that child's right to "liberty" under the Fourteenth Amendment, and that parents could not waive that right, the district court decided that the process due these children included a full range of adversarial procedures. Its determination in this regard reflects certain fundamental misconceptions, and ignored the evidence of a very careful and deliberate admission procedure which was involved for each admission in this case.

The lynchpin of the district court's reasoning is this Court's opinion in *In Re Gault,* 387 U.S. 1 (1966). However, *Gault* and its progeny which deal with juveniles' rights in the criminal area, have no application here however. Juveniles' procedural rights have been scrutinized by this Court in a series of cases beginning in 1948 with *Haley v. Ohio,* 322 U.S. 596 (1948), and continuing through the decision in *Breed v. Jones,* 421 U.S. 519 (1974). The clear trend of those decisions has been to require carefully selected procedural safeguards which have been deemed essential to fundamental fairness in criminal proceedings for adults. *McKeiver v. Pennsylvania,* 403 U.S. 528 (1970). This has been a disquieting process, for the Court has continued to recognize the implications of a more formal criminal justice system for juveniles. Thus, this Court in *McKeiver* avoided a "remake [of] the juvenile proceeding into a fully adversary process . . .", *Id.* at 545. Nevertheless, the harsh realities of the unfulfilled aspirations of the present system, *Breed v. Jones,* supra at 528, and the essentially criminal nature of juvenile proceedings have necessitated these reforms.

This Court has accordingly required that juveniles be afforded the rights of notice, counsel, confrontation and cross-examination in delinquency proceedings. *In Re Gault, supra.* Moreover, proof of delinquency is required to meet the traditionally heavy burden of beyond a reasonable doubt. *In Re Winship,* 397 U.S. 358 (1970). Similarly, in *Haley v. Ohio,* 332 U.S. 596 (1948), and in *Gallegos v. Colorado,* 370 U.S. 49 (1962), coercive procedures used in obtaining confessions from juveniles were ruled unconstitutional. However, this Court has not required that all rights Constitutionally guaranteed adults charged with a crime be made available to juveniles similarly accused. Thus for example, in *McKeiver* the Sixth Amendment right to trial by jury was not imposed upon the juvenile justice system.

The consideration of overriding importance which is derived from these cases is abundantly clear. Procedures required in the adult criminal process which go to the integrity of the fact-finding determination, the "was it done and did the defendant do it" determination, have been generally imposed on the juvenile justice system. Thus, confessions elicited under questionable circumstances, normally of dubious reliability, became even more unreliable when extracted from a child. *Haley, supra; Gallegos, supra.* Similarly, it was noted in *Gault* that "[w]ith respect to juveniles, both common observation and expert opinion emphasize that the 'distrust of confessions made in certain situations' . . . is imperative in the case of children from an early age through adolescence." *Id.* at 48. Similarly, a determination of a defendant's guilt or innocence is extremely suspect if that defendant has been denied the right to effectively challenge those findings through confrontation and cross-

examination, with counsel's assistance. *Gault, supra.* However, in further application of this principle in *McKeiver,* this Court concluded that "[t]he imposition of the jury trial on the juvenile court system would not strengthen greatly, if at all, the fact-finding function . . .". *McKeiver, supra* at 547.

The misstep in the lower court's approach in relying on *Gault* is apparent—it fails to distinguish between a medical diagnosis of mental illness or retardation, along with a recommendation for in-patient treatment, and a finding of guilt in a criminal proceeding. In the lower court's view, equating the two was justified because of the need to guard against inaccurate medical diagnosis in this area. Thus, for constitutional purposes, the district court would view the relationship between a child and his parents as equivalent to the relationship between the State and a child it accuses of criminality. There is nothing in *Gault* or any other decision of this Court which would support such a result.

The joint decision between a parent and physician to admit a child for in-patient treatment is a medical decision which is predicated upon careful medical evaluation. The critical "fact-finding" in the process is a medical diagnosis rather than an adjudication of guilt or innocence. If judicial evaluation of a recommended medical treatment plan is the underlying purpose for which the adversary proceeding ordered below is intended—and surely it is—then the timeless description of the juvenile court system rendered sixty years ago by Roscoe Pound will equally befit the courts that participate in this venture. After examining the system of juvenile justice Professor Pound found it to be ". . . an enterprise origin-

ally designed to use power and authority of law to achieve ends not amenable to legal means."[27]

An accurate medical diagnosis in the mental health area does not depend so much on whether a particular event actually occurred or whether that child actually did it. Rather the key is a medical evaluation predicated upon professional assessments of a multitude of factors. This may or may not involve some factual determinations.[28] But just as courts do not insist upon second-guessing a medical diagnosis in the area of physical medicine, they should be equally loath to do so in the area of psychiatry. Furthermore, factual determinations are a part of the diagnostic practice in physical medicine no less than in psychiatry. Thus, when a mother brings her two year old child to a doctor and explains the child's symptoms —mental, physical or both—a court hearing to check the accuracy of the mother's reports or the doctor's diagnosis and recommended treatment, is unwise, unwarranted, and without precedent.

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[27] Lemert, *Instead of Courts, Crime and Delinquency, citing* Roscoe Pound, the "Limits of Effective Legal Action": Twenty-Second Annual Report of the Pa. Bar Association, *National Institute of Mental Health,* 221, 225 (1971).

[28] These factual determinations in some cases may even involve the accuracy of reports of various conduct that could be classified as delinquent or criminal (790a). Moreover this conduct, or even reports of this conduct, may have even been the impetus for a child's parents to seek psychiatric help. But that is not to say that the child is hospitalized *because* of these reports, Thus the lower court's statement that children were institutionalized for truancy may be no more accurate than the statement that a person had heart surgery for chest pains—surely the chest pains brought the patient to the doctor and such a notation would undoubtedly appear on his admission note—but that of course is not the whole picture. (Tashjian at 650a-652a).

The lack of precision in psychiatric diagnoses has been made much of, and in many quarters, greatly exaggerated.[29] Nevertheless, to the extent that there is some degree of variability in diagnoses among mental health and retardation clinicians, that degree of variation is not unique to psychiatric medicine.[30]

In any event, it is unlikely that the adversarial procedure that has been appended to the medical diagnosis will accomplish much more than being ". . . a costly and time-consuming ratification procedure."[31] If the detection of mental illness or retardation is difficult for those specifically trained in the field, lawyers and judges will undoubtedly prove even less capable.[32] Thus, as in the field of education, the joint decision to admit the child for in-patient care ". . . requires an expert evaluation of

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[29] The conclusions reached in Rosenhan, *On Being Sane in Insane Places,* 179 Science 250 (1973), seems to cast doubt on the ability of psychiatrists to diagnose mental illness, and is repeatedly relied on for that proposition. However this study has however come under strong criticism. E.g. Roth, *Some Comments on Labelling,* 3 Bulletin of the American Academy of Psychiatry and the Law, 123-131 (1975).

[30] Meehl, *Why I Do Not Attend Case Conferences,* Psychodiagnosis—Selected Papers, 273-274 (Univ. Minnesota Press; 1973); Beck, *Reliability of Psychiatric Diagnosis: A Critique of Systematic Studies,* American Journal of Psychiatry, 210-216 (1962).

[31] Perr, *Minors and Institutionalization, supra* at 2. See also Wengler & Fletcher, *The Effect of Legal Counsel On Admissions to a State Menial Hospital: A Confrontation of Professions,* 10 Journal of Health & Social Behavior 66, at 68 (1969).

[32] Dr. Roth of the University of Pittsburgh has noted that "[i]f psychiatric diagnoses are neither reliable nor valid, . . . then of course courtroom prediction and courtroom diagnosis should cease immediately." *Some Comments on Labelling, supra* at 128.

cumulative information and is not readily adopted to the procedural tools of judicial or administrative decision-making." *Board of Curators of Univ. of Missouri v. Horowitz*, 98 S.Ct. 948, 955 (1978).

More importantly, none of the appellees ever questioned the accuracy of the medical diagnosis in their particular case—nor have they questioned the mode of treatment they have received. In fact the record clearly demonstrates that in each case the admission was premised upon, not one, but a series of thorough examinations and evaluations constantly underscoring the need for treatment. Pennsylvania law requires that an admission be preceded by at least one, and sometimes two[33] independent psychiatric or psychological[34] examinations demonstrating the need for hospitalization. The fact of the matter is that in this case each appellee received an average of more than three such examinations. For example, Nancy D. received two separate medical examinations and three different psychological evaluations, each of which was conducted separately, at different times, and concurred in Nancy's need for in-patient treatment.[35] Similarly, in addition to a complete neurological evaluation, Francis B. received two separate medical examinations, as well as a complete psychological assessment, prior to even being accepted at Haverford Hospital for treatment.[36] Furthermore, in each case there was a pre-admission interview or conference whereupon the facility determined the suitability of placement for itself.

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[33] Applies only to the mentally retarded.

[34] Applies only to the mentally retarded.

[35] Defendants' Exhibit No. 2.

[36] Defendants' Exhibit No. 9.

By all standards the lower court's assessment of "what process was due" missed the mark. *Matthews v. Eldridge*, 424 U.S. 319 (1976).[37] First, as the foregoing demonstrates beyond peradventure, each of the plaintiffs was admitted for treatment only after a thorough and exhaustive evaluation of the necessity for such treatment. The facts are that the appellees' interest in not receiving in-patient care needlessly was scrupulously protected by all concerned. The record in this case simply does not warrant the adversarial procedures imposed by the district court.[38] Secondly, it is clear that these newly mandated procedures will do very little to enhance the diagnostic process and thus avoid erroneous admissions for treatment. *Board of Curators, Univ. of Missouri v. Horowitz, supra.* In fact there is a substantial probability that the mandated procedures will at once be needlessly traumatizing for the entire family[39] dangerously delay, and in some

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[37] The measure of the process that may be due in a given situation lies in the balance of three factors: the private liberty or property interest, the risk of an erroneous deprivation of the interest, and the Government's interest. *Matthews v. Eldridge, supra.*

[38] Even assuming that there is an occasional erroneous admission, nowhere in evidence here, Dr. Eisenberg's query points to the flaw in the district court's approach:

> "Is it too much to suggest that the ineptness or even venality of some doctors or lawyers does not warrant the implication that all are so?" Eisenberg, *An Epidemic of Kew Gardens Syndrome: the Redefinition of Caring as Coercion supra* at 8.

[39] *Recognition and Protection of the Family Interests in Child Abuse Proceedings*, 13 Journal of Family Law 803 (1973-74); Record at 566a, 636a, 655a, 687a, 689a-690a, 697a-699a, 727a.

cases prevent, the child's treatment;[40] and only heighten the negative societal attitudes which unfortunately still attach to mental affliction in some quarters.[41]

Finally, Pennsylvania has a number of very practical concerns which argue forcefully against affirming the district court's order. The injurious, if not fatal, blows this order will deal to the community and respite care programs have already been noted. Additionally, it takes no citation of authority to offer that there is a scarcity of mental health and retardation resources throughout the nation, and Pennsylvania is no exception. Nevertheless the district court has ordered the diversion of some of the

[40] Futterman, *Bill No. 384—Civil Commitment of Mentally Ill Minors, supra* at 11. In addition to placing a tremendous strain on Pennsylvania's attempt to foster a growing network of community based treatment facilities which are privately operated for the most part, the order all but ends its program of respite care 7 Pa. Bull. 1433 (May 28, 1977). Under this system parents who assume the responsibility for caring for their retarded youngster may utilize state facilities for up to thirty days annually in order to obtain some necessary relief from the rigors such a responsibility entails. In this respect the District Court entirely misconstrued just such an admission as being evidence of callous disregard for the child (790a). In fact such respite admissions are favored because they allow the family to avoid or, at least, delay the admission of the child for full-time residential care. In describing the very situation which was mispereceived by the district court, Dr. Irwin N. Perr noted that "this procedure was not the capricious act of cold-hearted parents but rather part of a specific program to keep such children at home while at the same time providing some relief from the burden of constant supervision by the parents." *Some Recent Legal Psychiatric Developments in the United States, supra* at 139.

[41] *Bill No. 384—Civil Commitment of Mentally Ill Minors,* Futterman, *supra;* Snyder, *The Impact of the Juvenile Court Hearing on the Child, Crime and Delinquency,* 180, 181, 188 (April 1971).

most scarce resources, psychiatrists and psychologists, to adversary proceedings which will ultimately have little or no value in the treatment of the youngster.[42] In addition, the financial cost of this complicated process will indeed be substantial, and, when compared with the benefits to be yielded, becomes prohibitive. For all of these reasons then it is clear that by present Due Process standards Pennsylvania's system for the admission of children to mental health facilities by their parents or guardians is entirely sufficient thus necessitating reversal of the lower court.

II. ADMISSIONS OF CHILDREN TO PRIVATE FACILITIES BY THEIR PARENTS OR GUARDIANS DO NOT CONSTITUTE "STATE ACTION" FOR PURPOSES OF THE FOURTEENTH AMENDMENT

Private action is immune from the reach of the Fourteenth Amendment. Furthermore, the mere fact that an activity is subject to state regulation does not convert its action into that of the State for the purposes of the Fourteenth Amendment. *Jackson v. Metropolitan Edison Company,* 419 U.S. 345 (1974). *Moose Lodge No. 107*

[42] The hearing is specifically required to determine "whether, in fact, the child is mentally ill or mentally retarded" and if so whether the proposed method of treatment will be beneficial to the child (1081a). It is therefore obvious that, at a minimum, extensive medical testimony would be required for the tribunal to at least make an attempt at determining the accuracy of the diagnosis as well as the treatment which has been prescribed. See generally, *On the Voluntary Admission of Minors,* Michigan Journal of Law Reform, 189, 206 (Fall 1974).

v. Irvis, 407 U.S. 163 (1972). Before action can properly be attributed to the State, there must be a "sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself." *Jackson, supra,* at 351. Similarly, "[a] state's mere acquiescence in a private action . . ." does not render that action the State's. *Flagg Brothers, Inc. v. Brooks,* 98 S. Ct. 1729, 1737 (1978). "[I]t is quite immaterial that the state has embodied its decision not to act in statutory form." *Id.* at 1738.

In Pennsylvania, when a parent seeks to admit his child to a private facility, the State plays absolutely no role in the admission process. Private practitioners conduct the examinations and ultimately recommend the treatment. The parents and physician jointly select the facility which is most appropriate, and that facility's staff determines whether the youngster will be accepted for treatment. The State's only connection with the entire transaction is the licensing or approval of the facility to dispense mental health or retardation services.[43] Nevertheless, the district court found that the requirements of the Due Process Clause applied in this situation, just the same as if the state facilities and state officials were involved (1071a-1072a).

This holding cannot withstand the scrutiny of any of the state action tests enumerated by this Court. For example, this Court found no state action in *Jackson,* even though there was admittedly pervasive state regulation of the utility's activity there in question. Similarly, in *Flagg Brothers* this Court refused to expand the "state

[43] 50 Pa. Stat. Ann. §4201(8); §7105.

action" notion to include an essentially private transaction which was expressly authorized by state law. Just as New York was not involved, for Fourteenth Amendment purposes, in the warehouseman's sale in *Flagg Brothers,* nor was Pennsylvania involved in racial discrimination in a private establishment possessing a state license to operate in *Moose Lodge No. 107 v. Irvis,* 407 U.S. 163 (1972), Pennsylvania is similarly not involved in a parent's decision to admit his child to a private facility to receive medically recommended treatment.

Beyond being required to meet minimum qualitative standards, private mental health and retardation facilities in Pennsylvania receive absolutely no state supervision of the manner in which they operate.[44] Pennsylvania law has merely codified the commonly accepted notion that parents may authorize necessary medical treatment for their children.[45] Similarly, Pennsylvania statutorily regulate the dispensing of alcoholic beverages and utility shut offs. Yet, while these situations entail no state action, *Jackson v. Metropolitan Edison Company, supra, Moose Lodge No. 107 v. Irvis; supra,* the district court found that the State was involved here.

These private facilities are not staffed with state employees, receive no public subsidy,[46] and, by law, are not

[44] *See*: 50 Pa. Stat. Ann. §4201(4), (8); §4202 and §7105.

[45] Mere codification by statute of longstanding practices does not convert such activity into actions of the state, even if such codification actually changes the procedures involved. See, *Bosse v. Crowell Collier and MacMillan,* 565 F.2d 602 (9th Cir. 1977); *Melara v. Kennedy,* 541 F.2d 802 (9th Cir. 1976); *Anastasia v. Cosmopolitan National Bank of Chicago,* 527 F.2d 150 (7th Cir. 1975).

[46] Pennsylvania however does contract for services with a few of these facilities on a purely purchase of services basis.

part of the State mental health and mental retardation system.[47]. In fact, Pennsylvania is not even provided any advance notice whatsoever of new admissions to these facilities. Pennsylvania simply has no role in admissions to private mental health and retardation facilities. Thus, the admission of a child to a private mental health facility is a private transaction for purposes of the Fourteenth Amendment—notwithstanding the lower court's finding to the contrary.[48] The finding of "state action" here simply ignores the realities of the admission process. The California Appellate Court, in a case factually similar to this one, determined that:

> The decision to admit a minor [to a private licensed mental health facility] was a private one

[47] 50 Pa. Stat. Ann. §4201(4); §4202.

[48] In *Briscoe v. Bock*, 540 F.2d 392 (8th Cir. 1976), the Eighth Circuit held that dismissal of a physician by a state-licensed private hospital did not constitute "state action". It was undisputed that the hospital was a tax exempt, non-profit corporation subject to *extensive* state regulation. The hospital also received substantial financial assistance from both the state and federal governments. Accord: *Madrez v. Sorel*, 558 F.2d 303 (5th Cir. 1977); *Taylor v. St. Vincent's Hospital*, 523 F.2d 75 (9th Cir. 1975), *cert. denied*, 424 U.S. 948 (1976); *Watkins v. Mercy Medical Center*, 520 F.2d 894 (9th Cir. 1975); *Greco v. Orange Memorial Hospital Corp.*, 513 F.2d 873 (5th Cir.), *cert. denied*, 423 U.S. 1000 (1975); *Ascherman v. Presbyterian Hospital of Pacific Medical Center, Inc.*, 507 F.2d 1103 (9th Cir. 1974); *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974); *Doe v. Bellin Memorial Hospital*, 479 F.2d 756 (7th Cir. 1973); *Ward v. St. Anthony Hospital*, 476 F.2d 671 (10 Cir. 1973). *See also, Cannon v. University of Chicago*, 559 F.2d 1063 (7th Cir. 1976) (alleged discrimination in admissions procedures of private university; no state action found); *Fulton v. Hecht*, 545 F.2d 540 (5th Cir. 1977) (alleged civil rights violations by private kennel club; no state action found).

> between parents, doctor, and hospital. The state in no way became a party to this parental decision involving medical treatment for their minor child, any more than it would become party to a parental decision to send their child to a private boarding school, to summer camp, or to his room.

In Re John S., 135 Cal. Rptr. 893, 901, —— P. 2d —— (1977).

Nor does the "public function" doctrine apply in this case. There is no gainsaying that private hospitals provide a valuable service to those who seek help for mental problems, which service, in no small measure, benefits the community as a whole. However, we are not dealing with a service or obligation traditionally associated exclusively with sovereignty, such as eminent domain. This Court has recently rejected the invitation to expand the "public function" doctrine into a broad principle that all businesses "affected with the public interest" are state actions in all their actions, pointing out that:

> Doctors, optometrists, lawyers, Metropolitan and Nebbia's upstate New York grocery selling a quart of milk are all in regulated businesses, providing arguably essential goods and services, 'affected with a public interest.' We do not believe that such a status converts their every action, absent more, into that of the State.

Jackson v. Metropolitan Edison Company, supra at 354.

Similarly, the fact that Pennsylvania also provides mental health care in state operated facilities does not mean that private facilities providing similar care are sub-

ject to the same Constitutional requirements. This precise point was addressed in *Evans v. Newton,* 382 U.S. 296, 300 (1966):

> The range of governmental activities is broad and varied, and the fact that government has engaged in a particular activity does not necessarily mean that an individual entrepreneur or manager of the same kind of undertaking suffers the same Constitutional inhibitions. While a State may not segregate public schools so as to exclude one or more religious groups, those sects may maintain their own parochial educational systems.

In short, Pennsylvania has only recognized the parent's right to act; it does not require that such action be taken. A parent's "exercise of the choice allowed by law where the initiative comes from [them] and not from the State, does not make [their] actions in doing so 'state action' for the purposes of the Fourteenth Amendment." *Jackson, supra* at 357. All states have and must pass laws regulating many forms of private activity. Subjecting all behavior that merely conforms to State law to the Fourteenth Amendment would completely emasculate the entire state action concept. Following the guidelines articulated by this Court then, the district court's finding of state action in the admission to a private medical facility in Pennsylvania must be reversed.

III. THE DISTRICT COURT ERRED IN ITS TREATMENT OF BOTH THE PLAINTIFF AND DEFENDANT CLASSES

A. The Plaintiff Class:

Noting an "obvious lack of homogeniety" in the original plaintiff class, this Court previously advised that "we have the gravest doubts whether the class, as presently constituted, comports with the requirements of Fed. Rule Civ. Proc. 23(a)." *Kremens v. Bartley,* 431 U.S. 119, 130 (1976).[49] Accordingly, the district court was urged to "stop, look, and listen" before again certifying a class. The lower court was cautioned that "careful attention must be paid to the differences between mentally ill and mentally retarded, and between the young and the very young" Id. at 135-36.

Nevertheless the district court, after looking at these factors, made essentially no changes to the original class.[50] The lower court determined that the obvious dif-

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[49] As noted at the outset, the original class was certified as: "all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act (783a)."

[50] The court did create two sub-classes:

> (a) all juveniles committed as mentally ill to mental health facilities in Pennsylvania who are under the age of fourteen:
>
> (b) all juveniles committed as mentally retarded to mental health facilities in Pennsylvania who are age eighteen or younger.

Nevertheless for purposes of determining liability and ordering relief the district court treated the mentally ill and the mentally retarded the same, just as it had originally (844a).

ferences between infants and adolescents, and the retarded and mentally ill were unimportant for class certification purposes. The Court speculated that the adverse consequences attendant with mental affliction, e.g., stigma and risks of institutionalization, may be suffered by both the mentally ill and the mentally retarded. Finally, in its view, the risk of an erroneous diagnosis, as well as a parental conflict of interest, might occur in either group (1067a-1069a). Thus both groups, the mentally ill and the mentally retarded,[51] as well as the adolescents and the infants, were accorded the same treatment.

Rule 23(a) requires that representatives of a proposed class share common questions of law or fact with the unnamed class members, claims typical of all, and that they adequately protect the interests of those they purport to represent. Fed. R. Civ. P. 23(a)(1)-(4). In short, parties may not "represent a class of whom they are not a part." *Bailey v. Patterson*, 369 U.S. 31, 33 (1962). So too, the representatives of the class must "possess the same interest and suffer the same injury" as all others in the class they purport to represent. *Schlesinger v. Reservists to Stop the War*, 418 U.S. 208, 216 (1974).

Putting aside what has already been said regarding any stigma that may exist, the unbased fear harbored by the lower court concerning a conflict of interest between parents and their children, and the inability of professionals in both fields to adequately diagnose and treat

[51] For a discussion of the special considerations of the retarded with respect to adversary hearings, see, *Vecchione v. Wohlgemuth*, F. Supp. , E.D. Pa. (No. 73-162, filed Feb. 1973) (memo approving settlement).

their patients—there are serious problems with this plaintiff class. The first is the lack of representation for those of tender years in the class. In fact the youngest mentally retarded representative is fourteen years old,[52] while the youngest mentally ill plaintiff is seven.[53]

The distinctions are critical. The factual and legal considerations vary markedly between an infant and an adolescent, and even between an infant and a school-aged child. For example, the effects of an adversarial hearing may be quite traumatizing and counter productive for a child of two years of age, while on the other hand having very little effect on the seventeen year old. Indeed this Court noted that:

> This distinction between older and younger juveniles, recognized by state administrative authorities (and later by the Pennsylvania Legislature in its enactment of the 1976 Act), emphasizes the very possible differences in the interests of the older juveniles and the younger juveniles. Separate counsel for the younger juveniles might well have concluded that it would not have been in the best interest of their clients to press for the requirement of an automatic precommitment hearing, because of the possibility that such a hearing with its propensity

[52] Accordingly each of these plaintiffs receives the benefits of the 1973 regulations while the younger class members do not (pages 9 to 15, *supra*). As this Court pointed out, lumping these two groups "ignore[s] the effect of the regulations promulgated by appellants which makes [this] dramatic distinction between older and younger juveniles . . .". *Kremens v. Bartley, supra* at 135.

[53] Paul M., a mentally ill child, was seven years old when this suit was initiated on his behalf (Defendants' Exhibit No. 6).

> to pit parent against child might actually be antithetical to the best interest of the younger juveniles.

Kremens v. Bartley, supra at 135.

Thus, just as the district court failed to recognize that infants need special care and protection from the family that should be disturbed in only the most compelling circumstances, so also did it fail to take special note of the problems peculiar to adolescence.[54]

Although the district court made repeated reference to the risks of institutionalization as, another basis for the class certification, the class that it certified goes much beyond that. In fact, included within the class are children who may annually receive no more than two or three weeks of in-patient care in a public or private facility, as well as the child who is receiving mental retardation therapy in a small family-like group home. Once again, the fact of the matter is that none of the named plaintiffs represents the interests of these diverse groups. Each of the representatives was admitted to a public institution, which institution bears little resemblance to a community based group home for example. Similarly few, if any, of the considerations recognized by the lower court apply to a child who, by virtue of one very short admission each year, is able to remain with his family for the remainder of the year. The compelling differences between institutional care and community based care, as well as between respite admissions and long term admission are obvious. *See, e.g. Halderman v. Pennhurst,* 446 F. Supp. 1295 (E.D. Pa. 1977). Because of this, those who have been admitted for treatment in an institutional setting for relatively long term care cannot ad-

[54] *See, e.g.* testimony of Sugar 367a-368a; Miller 678a, 699a.

equately represent the interests of those who have not. Accordingly the doubts which this Court had originally were well founded, necessitating reversal of the district court.

B. The Defendant Class:

In addition to allowing this case to proceed as a plaintiff class action, the district court also certified a defendant class composed of:

> The directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare (956a).

All of the problems relating to a lack of homogeniety which were noted with respect to the plaintiff class, exist here as well. For example, this class not only includes the directors of state facilities who are employed by Pennsylvania, but also owners and operators of private facilities who are subject to absolutely no control by the Secretary, beyond licensing or approval. Some of these facilities are operated for profit, some are not—some may be similar to public institutions, while still others closely resemble middle class homes, or in some cases, private schools. The point is that just as with a plaintiff class, so too must the defendant representatives share a commonality of interests with all of the members of that class. So too must the defendant representatives be able to adequately defend the interests of the class members. *See: United States v. State of South Carolina,* 445 F. Supp. 1094, 1098 (D. S.C. Colum. Div.), *aff'd* 98 S.Ct. 756 (1978).

Examples of a lack of common interests within the defendant class abound.[55] While the state defendants will be able, through taxation, to ultimately fund the implementation of the order as it pertains to the public facilities, this is not so for the private facilities. Similarly, the state's administrative machinery might be utilized to provide hearings for admissions to public facilities, while the private facilities would undoubtedly be forced to resort to the courts. Likewise, the relief which was ordered, while amounting to a tremendous administrative burden for the State, may indeed be the death-knell to the very existence of any number of private facilities. In any event, the diversity of interest within the defendant class is clear. Accordingly, the district court must be reversed in this regard.

IV. THE RETROACTIVE ASPECTS OF THE LOWER COURT'S ORDER ARE IMPROPER[56]

Any person, regardless of age or affliction has a specific statutory right to test the validity of his admis-

[55] Generally, see testimony G. Radke, hearing on application for stay pending appeal, July 5, 1978.

[56] In light of the recent opinion in *Hutto v. Finney*, 46 U.S. L.W. 4817 (June 23, 1978), appellants no longer believe it necessary for this Court to consider whether the lower court's order violates the Eleventh Amendment to the United States Constitution. In *Hutto*, this Court found no constitutional violation in an award of fees and costs against the state based upon the bad faith of state officials. In so doing, the court clarified both the distinction, first noted in *Edelman v. Jordan*, 415 U.S. 651 (1974), between that retroactive relief barred by the Amendment and the prospective injunctive relief which is not, as well as the scope of proper "ancillary" costs. Similarly, the general availability of "compensatory" relief, approved in *Milliken v. Bradley*, 433 U.S. 267 (1977) as part of a court's broad powers in school desegregation cases, is now apparent. Since no "accrued monetary liability", Id. at 289 has been awarded, *Hutto* suggests that the lower court's order constitutes prospective injunctive relief proper under the Eleventh Amendment.

sion to a mental facility in Pennsylvania. 50 Pa. Stat. Ann. §4426, §7111(3) and §7206. The appellees in this case chose not to utilize these remedies but rather elected to institute this civil rights action. The single issue here is whether this was proper, or whether they were first required to pursue their state remedy under the principles laid down in *Preiser v. Rodriguez*, 411 U.S. 475 (1973). While plaintiffs' claims for prospective injunctive relief may have been appropriate in a §1983 action, *Gerstein v. Pugh*, 420 U.S. 103, 107 n. 6 (1974), their request for a retroactive injunction to apply to children then hospitalized was improper, and the court's order to that effect should be reversed. *See, e.g., Kendall v. True*, 391 F. Supp. 413 (W.D. Ky. 1975).

In *Preiser* several state prisoners brought a §1983 action alleging that they were unconstitutionally deprived of good conduct-time credits. They sought injunctive relief to compel the restoration of these credits which would have resulted in their release from prison. After noting various examples in which habeas corpus was the appropriate remedy, the Court noted that "in each case [the petitioner's] grievance is that he is being unlawfully subjected to physical restraint. . ." *Id.* at 486.

Since it was clear in *Preiser* that the complaint challenged the legality of their physical restraint, *Id.* at 487, the only remaining determination was whether or not

habeas corpus was the *exclusive* remedy by which they could proceed. This Court held that it was, and that therefore the plaintiffs' §1983 claims were barred for failure to exhaust their state remedies.

Federal exhaustion requirements apply to all cases where habeas corpus is an appropriate remedy.[57] Thus section 2254(b) merely refers to "a person in custody pursuant to the judgment of a state court". The fact that the appellees have not been committed by Court order is irrelevant. In *Preiser* this Court rejected a similar contention noting that an attack upon a state's administrative procedures by one seeking release is no less within the "core of habeas corpus" than an attack upon a prisoner's conviction, ". . . for it goes directly to the constitutionality of his physical confinement itself. . . ." *Id.* at 489. Habeas corpus was available to the plaintiffs in this case and in fact, would have been a complete remedy. *See, e. g., Hartman v. Scott,* 488 F.2d 1215 (8th Cir. 1973); *Heryford v. Parker* 396 F.2d 313 (10th Cir. 1968).

The appellees in this case were attacking the legality of their confinement. The complaint sought to enjoin the continued enforcement of the statute from which the appellants derived their authority to treat the appellees. Moreover, appellees' claims were predicated upon their expressed desire to be released from treatment. *See, e.g.,* 14a, 15a, 16a, 22a-23a. They were not challenging the conditions of their confinement, *Preiser, supra* at 498, nor have they sought damages. *Wolf v. McDonnell,* 418 U.S. 539 (1973).

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[57] 28 U.S.C. §2254(b) requires exhaustion of all state remedies before seeking habeas corpus in federal court.

The primary purpose for requiring exhaustion of state remedies is the concept of federal-state comity which is fundamental to "Our Federalism." *Younger v. Harris,* 401 U.S. 37, 44 (1971); *Preiser, supra* at 491. The lower court's order in this case ignored that principle by requiring complete retroactive application of its order. Such a clash can only be justified in limited cases. State law and procedure must obviously conform to the requirements of the Constitution, *Miranda v. Arizona,* 384 U.S. 436 (1966). But in this case it was clearly inappropriate for the lower court to order such a massive imposition upon the Commonwealth.

CONCLUSION

On the basis of the foregoing arguments and authorities, appellants respectfully suggest that the lower court must be reversed.

Respectfully submitted,

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FOR ARGUMENT.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1978

No. 77-1715

SECRETARY OF PUBLIC WELFARE
of Pennsylvania, et al.,

Appellants,

v.

INSTITUTIONALIZED JUVENILES in
Pennsylvania institutions for the mentally ill
and mentally retarded, et al.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

BRIEF FOR APPELLEES

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1978

No. 77-1715

SECRETARY OF PUBLIC WELFARE
of Pennsylvania, et al.,

Appellants,

v.

INSTITUTIONALIZED JUVENILES in
Pennsylvania institutions for the mentally ill
and mentally retarded, et al.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

BRIEF FOR APPELLEES

QUESTIONS PRESENTED

1. Mental institutionalization results in severe deprivation of liberty, social stigma, self-stigmatization and discrimination. Are young persons entitled to substantial Fourteenth Amendment due process procedural protections prior to involuntary indeter-

minate mental institutionalization upon parental application? If so, what process is due?

2. With reference to state-licensed facilities, is "State action" present for Fourteenth Amendment purposes where the State delegates to private entities a power not possessed by the State, the power to deprive persons of liberty without minimal due process protections, and, alternatively, is "State action" present where mental commitment in Pennsylvania is a power traditionally exclusively reserved to the state from the earliest colonial period continuously to the present?

3. Did the District Court abuse its discretion in certifying two plaintiff subclasses and a defendant class, where each shares essential legal and factual characteristics and where the requirements of Rule 23, F. R. Civ. Pro., are met?

4. Did the District Court err in requiring the defendants to assure that the plaintiff class members, committed to institutions unconstitutionally, receive constitutional state procedures in a state forum to determine whether they are mentally disabled and in need of institutionalization?

STATEMENT OF THE CASE

I. *Original Proceeding*

On November 16, 1972, plaintiffs in this class action filed their complaint against state officials[1] challenging

[1]The defendants included the Secretary of the Department of Public Welfare which "has the power and duty to enforce" the state mental health law, to "make all regulations necessary and *(continued)*

those portions of Pennsylvania mental commitment statutes which permit the involuntary indeterminate confinement of juveniles without substantial procedural safeguards including notice, counsel and opportunity for hearing.[2]

A three-judge court was convened pursuant to 28 U.S.C. §§2281, 2284 and, prior to trial, extensive factual stipulations were entered into. At a three day hearing before the three judges, the testimony of six expert psychiatrists was heard. The depositions of three other psychiatrists were entered into evidence.

The named plaintiffs were confined at Haverford State Hospital under the challenged statutes (133a-

(footnote continued from preceding page)
appropriate," and to "operate and assign functions to all state facilities" and the Deputy Secretary for Mental Health and Mental Retardation (277a). The superintendent of Haverford State Hospital, who is responsible for receiving applications for admission, commitment and release under the challenged statutes, was "sued as representative of the directors of all mental health facilities in Pennsylvania," all of which are under the authority of the defendants Secretary and Deputy Secretary (275a). All mental institutions in the state, state-owned or state-licensed, are required by law to utilize the commitment statutes and regulations. 50 P.S. §4102. Department of Public Welfare Regulations, Title 9100 (291a).

[2]The defendants agreed to the District Court's suggestion that a guardian ad litem be appointed for the plaintiffs pursuant to Rule 17(c) of the Federal Rules of Civil Procedure: "With regard to the technicality involved, I am really at the court's pleasure. I really do not object to the going through with Mr. Ferleger as a next friend." (250a). As here, federal courts uniformly exercise their power under Rule 17(c) to protect minor litigants' interests where potential for parent-child conflict is present. *E.g., Roberts v. Ohio Casualty Insurance Co.*, 256 F.2d 35 (5th Cir. 1958).

134a).[3] They were detained after a psychiatric examination which lasted "anywhere from an hour to three quarters of an hour" (47a) "or shorter." *Id.* The reasons for admission of these persons (as stated by the hospital) included truancy, incorrigibility, homicidal and suicidal behavior, chaotic family, talking incoherently, rebellion, aggressive behavior, threats and assaults to family members, temper tantrums, sexual acting out, foul language, drug use and hallucinations (135a-165a). Treatment for the group included drugs, individual, group and family therapies, confinement to closed locked units, schooling and confinement in seclusion rooms. *Id.*

Information regarding the mental institutionalization of all juveniles in Pennsylvania facilities was provided to the District Court (310a-316a).[4]

The facts in the following numbered paragraphs are stipulated by the defendants:[5]

---

[3]Children at Haverford State Hospital are held as civil "voluntary patients in the same treatment unit as those on criminal commitments." *See* Deposition of Barbara Armstrong (38a *et seq.*, 135a-165a).

[4]This information was provided in response to a discovery questionnaire which requested reports of the "reason" or "precipitating behavior" for commitment (27a, 773a). The extensive data are collated and summarized at 210a *et seq.*

[5]The stipulation and admission of these facts (522a-523a) was preceded by defendants' objection that additional data from the juveniles' medical records should be before the court (288a). To satisfy this objection, the court and the parties agreed that the records of ten randomly selected juveniles could be introduced into evidence (317a-363a). The random selections confirmed the representativeness and accuracy of the summaries given by the institution of the reasons for commitment. *See, e.g.*, the case in note 7, *infra*.

1. Children have been institutionalized in Pennsylvania mental health facilities for the following reasons as noted by the institution: "Runaway, incorrigible," "Violent episodes," "Hostile, attacked children, attempted to set home on fire," "Robbed gas station," "Stole truck, car," "Member of gang which participated in robbery," "Delinquent behavior," "Arson," "Runaway," "Runaway, truancy, delinquent behavior."

2. Mental institutions sometimes cooperate with parents and relatives "farming out their kindred into mental institutions for motives not always worthy."[6]

3. Children have wound up at institutions for the retarded for the following reasons, in addition to retardation:

> "Interim placement while family was on vacation."[7]
>
> A mother placed her child because "father out of household in the military."
>
> "Hyperactivity interfered with the routine of household and disturbed family members."
>
> "An institution accepted a child from a mother because of "desertion of father."

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[6]*Kent v. United States*, 401 F.2d 408, 416, n. 4 (D.C.Cir. 1968) (Burger, J., dissenting).

[7]More than ten months after this "vacation," this individual was reported still at the institution for the retarded; he was committed on July 20, 1972 for what his parents told the facility would be a one or two week stay. The facility reported the individual still committed as of May 31, 1973 (355a-362a, 773a). The District Court's reference to this case, 790a, is criticized by the defendants who, erroneously and *contra* the record, claim that this commitment was part of a state "respite care" program. Brief for Appellants at 46, n. 40.

Also, "Family conflicts," "Unmanageable at home, attitude of bold indifference, resents all discipline, compulsive eating," "Runaway, conflict with parents," "Neglect, Social Deprivation," "Neglect, unstable home environment," "No serious behavior problem; admitted due to parents' inability to provide a satisfactory home environment," "Sometimes hyperactive. Illegitimate," "Illegitimate. Inadequate mother."

4. One facility accepted a young retarded boy because "He has no playmates, planned activities, exercise. Presently he does nothing except sit in school and in front of the T.V. at home."

5. Three juveniles were committed to mental institutions because of physical ailments: ulcerated colitis, a psychosomatic complaint, weight loss.

6. Five juveniles were reported in one facility for not going to school.

7. A number of juveniles are committed for alleged drug-related activities.

Judgment was entered in favor of the plaintiffs,[8] the defendants appealed and this Court noted probable jurisdiction. While the appeal was pending, the Pennsylvania legislature enacted the Mental Health Procedures Act, 50 P.S. §7101 *et seq.* (hereafter, the "1976 Act") which altered commitment procedures for persons alleged to be mentally ill. In view of the effects of this statutory change, this Court held that the class action originally approved no longer met the requirements of Rule 23(a) and vacated and remanded "for consideration of the class definition, exclusion of

[8]Because important changes were made by the District Court after remand, the 1975 opinion and order (783a *et seq.*, 843a *et seq.*) are not summarized at this point.

those whose claims are moot, and substitution of class representatives with live claims." *Kremens v. Bartley*, 431 U.S. 119, 135 (1977).

II. *Procedural History on Remand*

On remand, plaintiffs filed an amended and supplemental complaint (875a *et seq.*). Nine of the twelve named plaintiffs included every juvenile committed as mentally ill under the 1976 Act to Haverford State Hospital at the time of filing (945a). Three of the plaintiffs were committed as mentally retarded to other institutions under the 1966 Act, 50 P.S. 4101 *et seq.*[9]

As in the initial proceedings, a defendant class of all Pennsylvania facility directors was sued, as was the Secretary of Public Welfare.[10] Unlike some states, mental health facilities in Pennsylvania are not merely licensed to provide services; they "have been required and are required to utilize and act in conformity with the commitment and admission procedures in both the 1966 Act and the 1976 Act." (949a). When institutionalized juveniles object to their confinement, the defendant facility directors, relying on the state law,

[9]The defendants again agreed to the maintenance of the litigation by the guardian ad litem, at no point raising any objection to single counsel functioning in that capacity. *See* 945a. Defendants did attempt to restrict the guardian's access to his clients and their records. On motion, the District Court ordered the defendants to permit full access to medical records, institutional living areas and the plaintiff class members themselves. Orders of June 21, 1977 and July 25, 1977. On the guardian ad litem's functions, see 1073a-1074a, n. 39 and 40.

[10]*See* note 1, *supra*.

"do not provide counsel or take action to assure either discharge or a hearing on the juvenile's objection. . . ." (950a). A defendant class was certified.[11]

The District Court set March 31, 1978 for the final hearing on the merits and ordered the parties to advise the court whether additional evidence would be submitted. Plaintiffs offered to submit expert testimony on "possible differing considerations between the young and very young and between those persons alleged to be mentally ill and retarded." (960a, citing 431 U.S. 119, 135). The defendants offered to produce no testimony.

Welcoming such expert testimony on questions raised by this Court, the District Court directed that it be presented by deposition.[12] Plaintiffs took the deposition of the Assistant Commissioner for Mental Retardation for the Department of Mental Health, Commonwealth of Massachusetts (972a *et seq.*). The defendants provided no expert testimony, or any factual testimony whatsoever.[13] The Commissioner's testimony stood uncontradicted.

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[11]For the District Court's memorandum and order on this issue, *see* 956a *et seq.* Counsel for several state-licensed facilities who were present at the final hearing made no objection, then or at any time, to the all-inclusive class definition and did not seek to present any evidence. Hearing of March 31, 1978.

[12]Hearing of March 31, 1978.

[13]Throughout their brief, defendants repeatedly make "factual" assertions regarding the differences between the young and very young and the mentally ill and the mentally retarded. These assertions, which bear no references to the record, are not based on any evidence in the case. In fact, the only evidence on these matters after remand is the expert testimony cited in the text.

At the final hearing, an extensive factual stipulation was entered into evidence (943a *et seq.*) as were portions of the named plaintiffs' medical records. The court accepted the parties' agreement to include in the evidence on remand "all testimony, depositions, exhibits, interrogatories, objections and rulings" from the original proceedings (950a, 1066a, n. 17).

III. *The Haverford State Hospital Plaintiffs*

The score of buildings at Haverford State Hospital, located in a rural/suburban area outside Philadelphia, include Building 14, a structure with two large wards. The west ward houses geriatric patients; the door to it is generally unlocked. The east ward houses juveniles (948a).

Entry into the children's ward is through a locked door bearing a sign which reads, "VISITING HOURS—1:30-4:30 Weekends and Holidays. No evening visits." (948a).

The ward consists of two hallways which cross at a glass-walled nursing station. One hallway continues from the entrance door to a large dormitory area for male patients. Along that hallway are two carpeted unfurnished rooms used for "seclusion" or "time-out" purposes. The second hall has a large dayroom at one end and, at the other end, a large dormitory area for female patients (949a).

In the nursing station is a bank of television monitors which is used to surveil the patients in all areas of the unit, including the halls and dormitories (949a). A week before the final hearing, the monitors in the dormitory area were switched off (Oral stipulation at

March 31, 1978 Hearing). Adjacent to the building are playing areas fenced in by chain link fences about 12 feet high (949a).

The named plaintiffs at Haverford ranged in age from 7 to 13 years. A county child care agency was involved in three of the nine commitments.[14] All were committed to the institution simply upon the application of a parent or guardian and its acceptance by the institution pursuant to Section 201 of the 1976 Act. There is nothing in the record to indicate that anything more than Haverford's typically brief psychiatric examination by a staff doctor preceded these commitments. *See* Deposition of Barbara Armstrong at 47a, 1059a, n. 11, 1061a, n. 15. The admission process includes a pre-admission contact or interview with a social worker and other staff (this may be the same day as admission) and an interview of the child by a psychiatrist, recorded in an admission note on the day of admission. The admission note summarizes the factual and psychiatric basis thought to justify the commitment.[15]

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[14]Thus, the defendants are in error when they state that "[i]n this case each of the appellees' parents sought medical help. . . ." Brief for Appellants at 30. For the entire class, the record indicates about 15% are not committed by their parents (933a, 952a at par. 45).

[15]Paragraph 37 of the Complaint, 884a, admitted by the defendants at 919a. The single or multiple "independent" examinations the defendants claim are required and provided, Brief for Appellants at 44, are not part of the procedure.

Although defendants were given the opportunity to demonstrate that referral material was used in deciding whether to confine the plaintiffs, the District Court found that "there is still

(continued)

These admissions notes, and the circumstances of the named plaintiffs, illustrate the great range of disputed behavior and facts surrounding the commitments and the unstable and conflict-ridden family situations of these young persons.[16]

Kevin S.

Kevin's mother, who is separated from his father, has a history of serious mental illness, including suicide attempts and hospitalizations. She was institutionalized when Kevin's elder brother was born. When pregnant with Kevin, she returned to the institution and, she admitted to Haverford State Hospital staff, "lied" to get in again.

At home with his mother, Kevin was physically abused. Most of his early life was spent in foster homes.

At the age of 12, Kevin was brought to Haverford State Hospital by the county child care agency and his

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(footnote continued from preceding page)

little evidence showing in what way, if at all, these records were used during the admissions process." (1061a, n. 15).

State procedures allow the most extreme summary commitment "process." As the District Court described the experience of one of the named plaintiffs:

> Hospital records show that Edward was not informed that he was to be admitted to a mental health facility prior to his admission date, but rather was told that his parents were taking him to a new school. He was extremely upset by the admission process, expressing fears about being in a hospital with "crazies" and being confined "like a prisoner."

1064a. In another case, the admission form for Francis B. was signed in blank. Defendants' Exhibit 9.

[16]The descriptions in the text are from the opinion of the lower court (1062a-1065a), supplemented by the medical records in evidence (Defendants' Exhibits 1 through 12) and the defendants' answer to the complaint (916a *et seq.*).

mother and was committed under Section 201 of the 1976 Act. After he was admitted, a psychiatrist interviewed Kevin and prepared an admission note which gives as the "reason for admission:" "Difficulties adjusting to school and family (mother). Exhibited bizarre behavior in school that has included making inappropriate sounds and laughing inappropriately." There is no indication in the records of Kevin's admission that he was ever asked for his comments or version of the behaviors he was accused of.

Haverford's psychosocial history of this plaintiff notes that his mother actively uses social systems "to the point of abuse" and concludes:

> It is felt that much of Kevin's problems come from living with a schizophrenic mother and having a very unstable and abused early life.

Richard S.

The county child care agency committed Richard S. to Haverford under Section 201 of the 1976 Act when he was 12.

Richard S. did not live with his mother until he was two years old and he stayed with her only until he was four when he was placed in an agency's children's cottage, later to be cared for in other homes for children.

The first psychiatric evaluation recorded for Richard S. in the hospital records was made the day of his admission and gives as the "reason for admission:" "Inability to adjust to open setting. History of self harm and running away." This evaluation contains no indication of whether Richard S. was given any opportunity to respond to the alleged basis for his institutionalization.

James Paul M.; Edward B.; Raymond C.

At age 7, James Paul M. was committed to Haverford by his father. His mother had died about one year before. The admission note gives "Uncontrollable behavior. Learning disability" as the reason for admission, with no further detail.

Plaintiff Edward B. was referred to Haverford by his private psychiatrist, Dr. Carl Hammer, who, it happens, is also a part-time psychiatrist at the institution. Edward is an adopted child.

Pursuant to Section 201 of the 1976 Act, Edward's parents signed him into the institution, having admittedly tricked him into accompanying them. The admission note records the extent to which his parents' actions and the hospital's procedures traumatized the 11 year old:

> Eddie then opened up with many feelings about being tricked into coming by his parents. He expressed feelings about them not caring for him and wanting to get rid of him. Both parents acknowledge that they had "tricked him" because they were fearful he would hurt or threaten to hurt himself. They admitted that they had not told him until that morning and had omitted the fact that this was a psychiatric hospital. Eddie's response to this was to make promises that he would change if he could stay home. * * * Eddie continued with his fears of being in a "crazy" hospital and of getting hurt by other patients—both adults and children. He also spoke of the high fences and of being kept in, like a prisoner.

Raymond C. was committed to the institution the day he was first seen at the facility. Under Section 201 of the 1976 Act, he was committed by his father who

had a drinking problem, according to the hospital's records. Institutionalized for "evaluation" initially, the admission note states the "reason for admission" as "History of uncooperative behavior including run away from school. Problems in community with stealing and destroying property. Has a learning and hearing problem."

William B.; Francis B.

Committed to the institution under Section 201 at the age of 9, William B. had been born to parents who separated when he was an infant. Two years prior to the commitment, William began living with his father in a home with a stepmother and two stepbrothers.

The reasons given by the institution for his commitment were "Uncontrollable behavior; preoccupied with matches, set a rug on fire, turned the gas burners on in the house, throws things out the window."

According to the hospital records, William B.'s life with family members subjected him to situation of extreme inconsistency, disorganization and lack of structure. His natural mother's lifestyle was erratic and she reportedly abused him.

Francis B. was about 9 when he was committed to Haverford, originally under Section 403 of the 1966 Act. This admission was at the request of his father who signed admission forms which omitted the proposed patient's full name and any identifying information. Francis' father later executed a commitment under Section 201 of the 1976 Act.

This young plaintiff comes from a disorganized family which has rejected him. As a social history a month before his confinement observes, "One of the

most distressing aspects of this case is the almost total rejection of Frankie by everyone in his family." His father has a drinking problem, the records indicate that the "parents are in need of help also as there is some question here of physical abuse" and, at the pre-admission interview, it was apparent that "Frank could no[t] do right in parents' eyes."

The admission note contains unamplified allegations of "difficulties adjusting to school" and states that Francis B. "has been described as hyperactive . . . clowning in order to get attention." A psychiatric evaluation received by the institution in referral material states, "I cannot describe him as hyperactive. In the first interview his mother seemed more hyperactive than he did."

Maria L.; Thomas W.

Maria L. was committed to the institution by her mother at the age of 11 pursuant to Section 201 of the 1976 Act. The "reason for admission" was stated by the psychiatrist to be "Difficulties adjusting to school because of aggressive behavior. Difficulties adjusting within the family."

Relationships between Maria and her parents are strained in several ways. She is the third of four children and Haverford's psychosocial history reports that

> The youngest is given special attention by Mr. L___ because Mrs. L___'s pregnancy with him kept her from divorcing Mr. L___. Mr. L___ does not want to assume any responsibility in raising the children or helping with home chores. He formerly spent a great deal of time away from

home, usually drinking, but now stays at home more, although he still drinks a good deal. Mrs. L___ does not see the drinking as a problem.

Maria's mother "has had near mental breakdown from the strain of the children" and, several times, tried to choke Maria, according to the same history of the case.

Thomas W.'s parents have an unstable marriage. After a severe beating which resulted in the child's hospitalization at the age of 9, Thomas' case came to the attention of social service agencies and his mother and stepfather were arrested.

The county child care agency, which has custody of Thomas W., committed him to Haverford from the County Juvenile Detention Center, first as an emergency commitment and then under Section 201 of the 1976 Act. While at the detention center, shortly before his commitment, he was given a psychiatric evaluation by John Fong, superintendent of Haverford, in his capacity as a "consultant." Haverford's stated "reason for admission" is "Fire setting, rages of 5-6 hours, during which he is assaultive, destructive and sets fires."

The Haverford State Hospital plaintiffs described above are not a selection from a larger group; every juvenile committed to Haverford under Section 201 at the time the suit was filed is included (945a). Also, absolutely none of the plaintiffs had ever been institutionalized before the commitments described above; it was their first time in the institution (910a, 924a).

IV. *Plaintiffs Committed Under the 1966 Act*

Pennhurst State School and Hospital is located in a rural area of Pennsylvania near Valley Forge. Built in the first decade of this century, it is unaccredited by the Joint Commission on the Accreditation of Hospitals.[17]

Plaintiff George S. was committed to Pennhurst under Section 402 of the 1966 Act by Catholic Social Services, an agency which was caring for him under contract with the Philadelphia Welfare Department which had legal custody of him. George was abandoned by his parents. From the first year of his birth until 6 years later (when he was committed to the institution), he lived with a foster family.

When his foster mother was hospitalized and, for a time, unable to care for George, he was placed in another foster home temporarily. Because of crowded conditions in that home, the placement was terminated; Catholic Social Services then signed George into Pennhurst.

Built in 1897, Polk State School and Hospital is located in a rural community about 80 miles from Pittsburgh. The remaining two plaintiffs are incarcerated at Polk.

At the age of 6, in 1967, the year her parents divorced, Gina S. was placed in a county infants' home. Three years later, she was removed by her mother and taken directly to Polk where she has remained since.

Gina S. was committed under a law, invalidated in 1971, which permitted any two doctors to certify the

[17]The shocking conditions and total lack of care at this institution are detailed in *Halderman v. Pennhurst State School and Hospital*, 446 F.Supp. 1295 (E.D. Pa. 1977).

indefinite commitment of any person.[18] No commitment papers were executed from 1971 until 1975 when the plaintiff's mother signed an application for commitment under Section 402 of the 1966 Act.

Nancy Louise D. was born in 1960. Both her parents were alcoholics and both were mentally retarded. In 1961, Nancy Louise was placed under the guardianship of the county welfare department which placed her in foster care until 1968 when she was taken to Polk.

"Her application form for admission shows that she was admitted under the authority of the Mental Health Act of 1951, rather than the 1966 Act then in effect." (Opinion at 1065a, n. 16). No commitment forms have ever been executed under the 1966 Act. Polk's director, however, purports to maintain her confinement under Section 402 of the 1966 Act.

George S., Gina S. and Nancy Louise D. are all mentally retarded to some degree. There is nothing in their medical records indicating that their mental condition required institutional care, rather than the non-institutional care they had been receiving prior to commitment.

V. *The District Court's Decision*

Holding that the plaintiffs' constitutional liberty interests are implicated by institutionalization, and that parents and guardians cannot waive young persons' constitutional rights, the District Court, with one judge dissenting, mandated certain due process

[18]Section 404 of the 1966 Act, 50 P.S. §4404. This statute was declared unconstitutional in 1971 in *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F.Supp. 966 (M.D.Pa. 1971) (Three-Judge Court).

procedures to protect against erroneous commitments and to assure the least restrictive alternative form of care.

Brief descriptive reference to the District Court's decision is necessitated by the defendants' repeated misleading and deficient characterization of the judgment now before this Court. Defendants misconstrue the relief that was granted. Further, defendants totally ignore (and, significantly, do not challenge) the detailed factual findings below.

The District Court *did not order* that every child committed "be provided two separate adversary hearings." Brief for Appellants at 20. The District Court *did not order* "a court hearing to check the accuracy of the mother's reports or the doctor's diagnosis and recommended treatment. . . ." Brief for Appellants at 42. The District Court *did not order* procedures "to enhance the diagnostic process." Brief for Appellants at 45.

The only procedures absolutely required in every case are notice[19] and "counsel or other trained representative." (1093a). The court explained the need and function of the child advocate in this way:

> It may not always be necessary to appoint a lawyer so long as a substitute procedure adequately protects the child's interest. For example, it may be sufficient to appoint a guardian, trained in the

[19]Notice is not required prior to confinement in the institution. The order specifically declares that parents and guardians "may initiate the temporary detention" of young persons (1092a) and that a probable cause hearing need not be held for three days after the commitment (1094a). Notice must be received 48 hours before the hearing (1093a).

> mental health field, who would advocate the child's interests or alternatively, have the power to retain a lawyer to do so. The important point is that the child must have a capable advocate who has the sole responsibility of advancing the child's best interests. However, until alternative procedures are designed which will adequately protect the child's interests, we adhere to our conclusion that counsel is required.

Opinion at 1079a, n. 47. Once the juvenile and his or her representative has notice of an intention to prolong the institutionalization, the decision is made whether to waive or insist upon the hearings and further rights recognized by the court (*i.e.*, presence at hearing, confrontation, standard of proof). *See* 811a, n. 26 (original opinion), 1079a, n. 48 (current opinion), 1094a (current order).

Contrary to the defendants' claims, the District Court was crystal clear that "we neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made." (811a, n. 26). In its recent memorandum on the motion to stay, the court noted the major likely practical effects of the flexibility inherent in the procedures:

> In fact, the witness who testified on behalf of the Devereaux Foundation stated that he believed that the majority, if not all, of the 300 class members at Devereaux are content and, given the choice, would choose to remain there. In the case of many of these juveniles, a hearing might be waived.

Memorandum of July 17, 1978 at 4.

Regarding the nature of the forum for hearings which are held, the lower court explicitly chose to "state only that the tribunal must be neutral and unbiased." (1082a). The state is left "free to develop its own safeguards (1079a) to protect plaintiffs' rights. The order does not decide "[w]hether the tribunal should be judicial or administrative." (1082a and *id.* at n. 53).

If a hearing occurs in a particular case, the neutral tribunal will determine the factual questions which arise inevitably. The decision-maker will resolve "whether, in fact, the child is mentally ill or mentally retarded. If this determination is affirmative, the tribunal should proceed to determine if commitment is necessary, if it will be beneficial to the child, and if it is the least restrictive alternative." (1081a). "While the tribunal should make findings to support its determination, these findings need not necessarily be made formally." *Id.*

On remand, the District Court refined and set forth the factual findings which are the foundation of its legal conclusions. The defendants have not challenged these factual findings on appeal. Some of the major findings of the court are summarized below:

> 1. A serious and injurious stigma attaches to institutional commitment whether the juvenile is classified as mentally ill or mentally retarded (1067a). This stigma may be "a more lasting abridgement of personal freedom than imprisonment for the commission of a crime." (795a).
>
> 2. Both mental illness and mental retardation (in part, for different reasons) are subject to error in diagnosis and identification (1067a-1068a) "substantially different from the treatment of other medical conditions." (1077a-1078a).

3. Conflicts between the interests of parents and juveniles frequently arise respecting commitment and parents often institutionalize their children for reasons unrelated to the young persons' needs and best interests (798a, 1068a-1069a).

4. Deprivation of liberty is inherent in institutionalization and its serious, isolating and dehumanizing effects which apply to both the mentally ill and mentally retarded, regardless of whether the institution is state-operated or state-licensed (1069a-1070a).

5. The dangers of misclassification and the stigma of institutionalization fall more heavily on the younger child.

6. With respect to the mentally retarded, the decision to institutionalize is often a long-term or even life decision (1078a, n. 45).

7. The effects of a hearing—on both children and parents—would not be traumatic but would be beneficial (1081a-1082a, detailing benefits).

8. Any potential trauma due to the hearing process can be avoided by waiver of the person's presence. Also, "any danger of trauma pales beside the potential severity of the deprivation of liberty suffered by a child needlessly institutionalized." (1082a).

9. Institutional staff have a conflict of interest in making decisions to commit (1083a-1084a).

The District Court entered judgment for the plaintiffs on May 25, 1978, granting declaratory and injunctive relief to assure that persons presently deprived of liberty under the invalidated statutes and persons who might be committed in the future receive the benefit of minimal due process procedures in a state-created forum. This appeal followed.

SUMMARY OF ARGUMENT

1. Mental institutions are generally underfinanced, understaffed and overcrowded. Commitment to such a residential facility necessarily entails a massive curtailment of liberty as persons are placed in a "total institution" in which every aspect of their lives is regulated by impersonal authority.

A powerful long-term effect on the individual's life reverberates long after release from the facility. Severe social stigma, self-stigmatization, job and license discrimination also result from the commitment to mental institutions for the mentally ill and the retarded. It is the fact of institutionalization, not the procedures used, which stigmatizes.

2. Mental commitment is generally considered a deprivation of liberty under the Fourteenth Amendment and the states are required to provide substantial procedures to protect persons from erroneous commitments. *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Baxstrom v. Herold*, 383 U.S. 197 (1966); *Specht v. Patterson*, 386 U.S. 605 (1967). *See also Chaloner v. Sherman*, 242 U.S. 455 (1917); *Dexter v. Hall*, 82 U.S. 9 (1872). The pervasive concern has been that no person may be caused to suffer a loss of liberty—for whatever reason—without stringent decision-making requirements designed to minimize the ever-present risk of error and to assure proper disposition of the case.

3. The defendants, invoking the "family's right of privacy" and "the sanctity of parental responsibility," maintain that a young person's constitutional right to liberty is not implicated at all in mental institutionali-

zation under parental commitment laws. This conclusion misconceives the applicable constitutional doctrine.

Two controlling principles emerge from the Court's decisions regarding parents and children. Where the state unreasonably intrudes into the family's domain and thereby jeopardizes the family's function and strength as the primary socialization mechanism, the state's intrusion will be struck down. *See Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Wisconsin v. Yoder*, 406 U.S. 205 (1971). In precisely parallel fashion, where parental decisions unreasonably jeopardize the young person's opportunities for growth into well-developed individuals, governmental intrusions into the family will be upheld. *Prince v. Massachusetts*, 32 U.S. 158 (1944); *Wisconsin v. Yoder, supra*.

The extent of control over juveniles by parents and guardians is broad enough to provide appropriate deference to the importance of the family but narrow enough to protect the independent personal interests of the most powerless of the family's members.

4. In other cases where constitutional rights of young persons have been at stake, but where family interests were not implicated, this Court has recognized minors' liberty claims, although the extent of such claims has been subject to possible limitation. *E.g., Erznoznik v. City of Jacksonville*, 422 U.S. 205 (1975); *Ingraham v. Wright*, 430 U.S. 651 (1977); *Carey v. Population Services International*, 431 U.S. 678 (1977).

One liberty interest of young persons which has repeatedly been identified by this Court as implicated

by the Fourteenth Amendment is the right to be free from physical confinement, for whatever purpose, in an institution. *See In re Gault*, 387 U.S. 1 (1967); *In re Winship*, 397 U.S. 358 (1970); *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971); *Breed v. Jones*, 421 U.S. 519 (1975). *See also Giacco v. Pennsylvania*, 382 U.S. 399 (1966). A constitutional liberty interest is discerned even if the purpose of the confinement is "clinical" treatment or "to save the child." There is no suggestion in any decision of this Court that parental endorsement of a decision to separate the young person from the home and confine him or her in an institution nullifies the juvenile's Fourteenth Amendment rights.

5. As the lower court's unchallenged factual findings and the record in this litigation shout forth, applications for commitment of young persons are not the expression of calm, conflict-free, rational, informed, reliable parents and guardians. On the contrary, the expert witnesses for all parties agreed that families seeking commitment are characterized by severe stress, disharmony and dislocation. The family structure is weakened. Parents will seek to institutionalize children for improper reasons. This stems from honest mistakes, ignorance, lack of awareness of alternatives to institutionalization, lack of community resources, or sometimes from malice or ill will.

Parents are not particularly good observers of children's behavior and symptoms in the context of the high feelings that run in these situations. They cannot be objective reporters of the behavioral background of the child; they often exaggerate and misinterpret the actions of their children. When these family dynamics are viewed in the framework of the alleged behavior

which precipitates the request for commitment, conflicts between the concerns and interests of the parents and the best interests of the child are apparent.

6. Stereotypes regarding the retarded and their mental institutionalization are tragically hardened and erroneous. A person's level of retardation, for example, does not predetermine his or her need for institutionalization. Many factors are more important in determining institutionalization of retarded persons, including family disorganization, demographic characteristics, parental attitudes toward childrearing and mental retardation, availability of community resources, and the professional philosophies of those consulted for advice. Inappropriate and unneeded institutionalization is often the unintended result. The only evidence on the family situation of the retarded, the expert testimony for the plaintiffs by the head of retardation for the Commonwealth of Massachusetts, confirms the trying situation faced by such families and the fact (found by the lower court) that no identity of interests may be presumed, no matter how well-motivated the parents might be.

7. The legal test to be applied is found in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), where the Court examined "whether there is any significant state interest in conditioning an abortion on the consent of a parent or person in loco parentis that is not present in the case of an adult." A direct and persuasive response to *Danforth* is that the constitutional interest in freedom from physical confinement without due process admits of no exceptions applicable here and that no asserted state interest

in other juvenile cases has overcome this liberty, no matter how rehabilitative or treatment-oriented the institution of confinement has been.

8. Previous cases, however, have not involved a parent or guardian acting to assure confinement. The only interest asserted here by the state is parental autonomy expressed by medically-advised deprivation of a person's liberty. Such an argument was expressly rejected in *Danforth* where the "conflict" situation "has already fractured the family structure." As in *Danforth*, any parental right to obtain mental health care for a child is no more weighty than the liberty right of a child proposed for institutionalization. The parental interest cannot act as an absolute limitation on the child's right. *Danforth, supra; Bellotti v. Baird*, 428 U.S. 132 (1976). Under *Danforth*, a countervailing state interest must be established by more than the unsubstantiated declaration of its existence; here, the record provides no support for any claim that "parental autonomy" is preserved or protected by commitment of young persons to institutions without due process protections. Other possible rationales for differentiating between the rights of young persons and adults are neither asserted by the defendants nor present in this case.

9. The critical question raised by *Danforth* is not "when rights conflict, which are paramount?" but "when presumed common interests in fact diverge, how can each be accommodated and protected?" There is a continuum of decisions made by parents and guardians regarding their wards. At one end are constitutionally trivial and intra-familial issues in which there is little, if

any, potential harm to the child. Along the continuum, parental powers are met with limits as their interests and desires diverge from those of young persons, in whom the state has an interest. As the parents' claims threaten to risk or unduly interfere with the child's, the divergence becomes so great that the parents' assertion of rights is not permitted to overshadow the social necessity of protecting young persons' independent interests. When viewed in terms of its nature and potential for harm, mental institutionalization—whether the commitment is erroneous or not—is an event near the end of the continuum at a point where the "parental autonomy" claims are properly muted to the extent necessary to protect the "liberty" claims of the child who is being removed from the home and placed in an institution.

10. The involvement of psychiatrists, physicians or other professionals cannot act as a fail-safe in the commitment process. The field of psychiatry is beset with uncertainty of diagnosis and tentativeness of judgment. In addition to the factual disputes which crop up in every commitment, the very existence of mental illness and the need for institutional care are facts not amenable to purely medical termination. Institutional psychiatrists have multiple conflicts of interest in making commitment decisions. The situation is mirrored for mental retardation, although the reasons for mistakes in identifying the retarded are somewhat different (*e.g.*, confusion with physical characteristics, testing problems, incorrect developmental speculations). Parents of the retarded receive consultation from physicians which is typically

uninformed, without reasonable basis, and inappropriately and excessively oriented toward institutionalization. Professionals at retardation institutions and in the community are unable to make conflict-free referral recommendations or to sort out the inevitable factual disputes.

11. What process is due? The lower court's mandate is extremely narrow and limited. With the exception of notice of prolonged commitment and counsel or other trained representative, all rights may be waived, including presence at the hearings. It is expected that hearings will not be required in every case; a large number will be waived. The forum for any hearings which are held would be an "impartial tribunal" created by the state where the perspective and concerns of the parents or guardians could be fully aired. Many states already provide such hearings for young persons facing commitment.

12. The lower court found as a fact that any hearings would not be unduly traumatic for juveniles but would be beneficial, to the juvenile and his or her parents. The opportunity for hearings would result in agencies performing more effectively, the avoidance of many commitments, reduced use of institutionalization, and provision of more appropriate care in particular cases.

13. The requisites of due process found by the lower court to be appropriate are notice of prolonged commitment; counsel or other trained representative (for example, a guardian who would have the power to retain counsel, if legal assistance was required); a hearing before an impartial tribunal within a reasonable time after commitment (a probable cause hearing

after three days and, if necessary, a full hearing after two weeks); the right to be present; the right to confront and cross-examine witnesses and to present evidence; a clear and convincing standard of proof.

14. These procedures would significantly reduce the risk of error. They would also assure protection of the young person's right to care in the least restrictive alternative appropriate to the person's needs. The state has no significant interest in avoiding these procedures. Any cost is outweighed by the private interests and risk of error. Avoidance of institutional care and diversion of some cases to community-based programs will result in substantial cost savings to the state. The state has no interest in the erroneous or unnecessary confinement of any of its citizens, regardless of age.

15. The state statutes and regulations permitting parents to volunteer their children into mental institutions fail to protect the rights and interests of the plaintiffs. Referral systems and evaluations are faulty and provide a skimpy professionally unacceptable (and legally unacceptable) basis for commitment. The mentally retarded, who are limited in capacity to understand technical legal forms and procedures, are not assisted in any real way by the state's regulations. Young persons committed as mentally ill receive no effective protections under the state's present system.

16. "State action" is present in commitment of young persons to state-licensed facilities which are required to utilize and act in conformity with the challenged statutes and regulations. This is so on two alternative grounds:

a. The state has delegated to parents, guardians and institutions a power not possessed by the state, the power to deprive persons of liberty without minimal due process procedural protections. This is not a private commercial dispute and does not involve mere regulation of private business activities.

b. A detailed examination of the legal history of mental commitment in Pennsylvania demonstrates beyond peradventure that, beginning with the earliest colonial period of Pennsylvania history, through the Revolution and the State's first Constitution, and continuing through the 19th Century and into the 20th Century, mental commitment has been a sovereign power strictly under the control and perogative of the State. Although procedures shifted and varied, any commitment to any institution, whether "public" or "private," was a matter of exclusive and paramount state concern. Mental commitment has never been simply a private matter. Like education, elections, tax collection, fire and police protection, commitment of citizens to mental institutions in Pennsylvania has been a power traditionally exclusively reserved to the State.

17. On the propriety of the plaintiff subclasses, the defendants raise objections that were not raised at any point in the litigation below. Defendants should not be permitted to sit silent through a lawsuit, and give no hint of opposition to proposed subclasses, and then to claim error for the first time on appeal. In any event, on their merits, the objections must be rejected. After careful and reflective analysis, the lower court determined that plaintiff subclasses including all ages

of juveniles with common legal and factual connection with the state are proper. In addition, all persons subjected to institutionalization's dangers, whether for a month or for long term care are properly members of the same class where due process protections are held to apply to the very deprivation of liberty itself; the lower court balanced the length of commitment factor in determining what process is due. There was no abuse of discretion in certifying the plaintiff subclasses.

18. Nor is there any abuse of discretion in the certification of a class of defendant institutional directors where each is adequately represented by the Attorney General of Pennsylvania and where each of the 400 members of the class, as a practical matter and by operation of state law, would be bound by the result, and where none of the participating institutions objected to going forward.

19. The District Court's order that all young persons committed without hearings or counsel or other trained representative receive the benefit of the minimal process discussed above was proper and consistent with the mandate of *Preiser v. Rodriguez*, 411 U.S. 475 (1972), and *Wolff v. McDonnell*, 418 U.S. 539 (1973). The federal court did nothing to order or to speed any inmate's release. The court simply required the state to hold state proceedings where a state tribunal would make all individual determinations. This approach has been endorsed by this Court. *Gerstein v. Pugh*, 420 U.S. 103 (1975). *See Gomez v. Miller*, 341 F.Supp. 323 (S.D.N.Y. 1972), *aff'd sub nom. Miller v. Gomez*, 412 U.S. 914 (1973).

ARGUMENT

I.

PRIOR TO INVOLUNTARY INDETERMINATE MENTAL INSTITUTIONALIZATION UPON PARENTAL APPLICATION, YOUNG PERSONS ARE ENTITLED TO SUBSTANTIAL PROCEDURAL PROTECTIONS.

A. Institutionalization Results in Severe Deprivation of Liberty, Social Stigma, Self-Stigmatization and Discrimination.

Mental institutions are generally underfinanced, understaffed and overcrowded.[20] Commitment to such

[20]Hobbs, *The Futures of Children* 127-128 (1975). Provost Hobbs describes the familiar physical and fiscal realities in his report:

> Most public institutions are grossly and chronically underfinanced (Kugel, 1969). During 1966 and 1967 the per diem costs in United States institutions ranged from about $3 to $12 per person (U.S. Department of Health, Education and Welfare, 1968). In stark contrast, five of the largest United States zoos were spending, in a comparable period, an average of over $7 for their large animals (Kugel, 1969, p. 3). Further, in 1966, general hospital care cost more than $40 per day (Butterfield, 1969, p. 18).
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> * * *
>
> Overcrowding is commonplace. Many residential facilities have as many as 25 to 50 percent more than they were intended to serve. Buildings that are old and poorly designed also create problems. For instance, lavoratory and toilet facilities are often poorly maintained and may even be nonfunctioning. Ancient facilities may make it difficult if not impossible to prepare food in a sanitary fashion; and climate control may be so inadequate as to leave buildings either too hot or too cold (Kugel, 1969, p. 405; Blatt and Kaplan, 1967). Equally inadequate are modern complexes of steel, chrome, and glass, when human caring is absent.

Id.

a residential facility necessarily entails a "massive curtailment of liberty," *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), as persons are placed in a "total institution" in which every aspect of their lives is regulated by impersonal authority.[21] The dangers and negative effects of institutional treatment programs are well-known.[22] The process results in what one of the

[21]Goffman, *Asylums* (1961). As early as 1938, a federal appellate court recognized the similarities between the deprivations of liberty of people in mental institutions and those in prisons. *Barry v. Hall*, 98 F.2d 222 (D.C. Cir. 1938). A detailed comprison of the conditions in a psychiatric treatment center and a state prison—demonstrating the restrictiveness of the mental facility—is provided in "Brief of Donald McEwan, Pro Se" in Katz, Goldstein & Dershowitz, *Psychoanalysis, Psychiatry and the Law* 700-702 (1967). For discussion of the nature of mental treatment in the United States, *see* Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1316-1376 (1974); Deutsch, *The Mentally Ill in America* (2d ed. 1949); Grob, *Mental Institutions in America: Social Policy to 1875* (1973); Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (1971); Kittrie, *The Right to Be Different: Deviance and Enforced Therapy* (1971); Rosen, *et al., The History of Mental Retardation: Collected Papers* (1976).

[22]Barton, *Institutional Neurosis* (2d ed. 1966); Belknap, *Human Problems of State Mental Hospitals* (1956); Gralnick, *et al.*, "Mental Patients in Transition" in Greenblatt, ed., *Mental Patients in Transition* (1961); Stanton and Schwartz, *The Mental Hospital* (1954); Wing and Brown, *Institutionalization and Schizophrenia* (1970); Vail, *Dehumanization and the Institutional Career* (1966); Klaber, *Retardates in Residence: A Study of Institutions* (Project RD-1816-P, Social and Rehabilitation Service, HEW, State of Connecticut, University of Hartford). *See* testimony of Dr. Ingall at 596a, Dr. Feiner at 474a-475a, Commissioner Glenn at 985a-990a.

defendants' own expert witnesses calls "an emotional deficiency disease" (715a). The "institution extracts, takes away liberties and opportunities in all areas once a person is placed there." Testimony of Commissioner Glenn at 986a.

Most juveniles entering the institutional mental health system have never received any psychiatric treatment before, stay longer than adults,[23] and a large proportion do not suffer from any major "illness."[24] Nevertheless, all are subjected to the process of institutionalization which can "make children sick," according to Nicholas Hobbs in his report volume for the HEW-sponsored Project on Classification of Exceptional Children:

[23]Most juveniles admitted to mental hospitals (53% in 1969) never before received psychiatric treatment; the figure for all age admissions is only 38.7%. Dept. of Health, Education and Welfare, NIMH, Statistical Note 90, *Utilization of Psychiatric Facilities by Persons Under 18 Years of Age, United States, 1971*, Table 9. Once in a private or public mental institution, juveniles stay longer than adults. *Id.* at Table 8.

[24]In 1975, the leading primary diagnosis of juveniles admitted to state and county mental institution was "transient situational disorders and behavior disorders of childhood" which accounted for 54.3% of all juvenile admissions. Dept. of Health, Education and Welfare, NIMH, Statistical Note 138, *Diagnostic Distribution of Admissions to Inpatient Services of State and County Mental Hospitals, United States, 1975*. Most of the nine Haverford plaintiffs here have been given such diagnoses. These relatively minor "transient situational disturbances" are those that "occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* at 48 (2d ed. 1968).

Go to a big state mental hospital in almost any state and ask to visit the children's ward. If you are allowed to visit, you will find people, children and staff alike, caught up in a no-exit game. Patients and staff play their roles, each defined by the other, both prescribed by elaborate regulations and procedures that serve one purpose: to maintain the stability of the institution. Most of these institutions are so large, so unwieldly, so antiquated in design, so poorly staffed, so burdened with the miseries of man that everyone involved must devote most of his energies to maintaining a steady-state situation. The metaphor of illness rules. Change in or deviation from role requirements cannot be tolerated. Apathy goes unnoticed. Precise adherence to role expectation is praised and rewarded, while deviations and serious efforts to change the system are punished. In such a setting, hospitals can indeed make children sick.[25]

The particular dangers of institutionalization for the retarded include a high rate of mortality (generally higher, especially for the young, than in the community); an adverse effect on intelligence and an abnormally high prevalence of personality disorders.[26]

[25]Hobbs, *supra* note 20, at 130. Institutional care during early childhood is especially to be avoided. There is strong evidence that one institutional admission of longer than a week or repeated admissions before the age of 5 are associated with increased behavior disturbances and instability in adolescence. Douglas, *Early Hospital Admissions and Later Disturbances of Behavior and Learning*, 17 Dev. Med. Child Neurol. 456 (1975); Quinton, *Early Hospital Admissions and Later Disturbances of Behavior: An Attempted Replication of Douglas' Findings*, 18 Dev. Med. Child Neurol. 447 (1976).

[26]Studies collected in Edgerton, *et al.*, "Mental Retardation System," in Hobbs, ed., *Issues in the Classification of Children, Vol. II*, 63-64 (1975).

Harmful stereotypical "institutional" behaviors (such as biting and head banging) are learned by the retarded who live in institutions.[27]

After the emergence of the first institutions for the retarded in the United States 120 years ago in an atmosphere of optimism, the facilities failed to fulfill their expectations for cure or rehabilitation. By 1880, the earlier prevention model was succeeded by a "pity model" which supported the provision of custodial care. By the turn of the century and with the development of the eugenics movement,[28] a societal image of the retarded as a danger and a menace to society became fixed.[29] As one commentator explains the effect today of this history:

> . . . many of our institutions, to this very day, operate in the spirit of 1925 when inexpensive segregation of the scarcely human retardate was seen as the only feasible alternative to combat a social menace. I am not proposing that this view is still held; I am proposing that most institutions function as *if this* view were still held.[30]

[27]Testimony of Commissioner Glenn at 987a-988a.

[28]*See Buck v. Bell*, 274 U.S. 200 (1927), upholding a statute growing out of this movement.

[29]For analysis of this development, *see* Baumeister, *The American Residential Institution: Its History and Character* in Baumeister and Butterfield, eds., *Residential Facilities for the Mentally Retarded* (1970); Kugel and Wolfensberger, eds., *Changing Patterns in Residential Services for the Mentally Retarded* (1969); *Halderman v. Pennhurst State School and Hospital*, 446 F.Supp. 1295 (E.D.Pa. 1977).

[30]Wolfensberger, *The Origin and Nature of Our Institutional Models*, in Kugel and Wolfensberger, *supra* note 29, at 129 (emphasis in original).

Institutions for the retarded are known to subject their inmates to regimented, impersonal and warehouse-like conditions.[31] For example, this is the way one federal court describes the daily routine in the institution to which plaintiff George S. has been committed for the past eight years:

> These institutions are the most isolated and restrictive settings in which to treat the retarded. Pennhurst is almost totally impersonal. Its residents have no privacy—they sleep in large, overcrowded wards, spend their waking hours together in large day rooms and eat in a large group setting. They must conform to the schedule of the institution which allows for no individual flexibility. Thus, for example, all residents on Unit 7 go to bed between 8:00 and 8:30 p.m., are awakened and taken to the toilet at 12:00-12:30 a.m. and return to sleep until 5:30 a.m. when they are awakened for the day, which begins with being toileted and then having to wait for a 7:00 a.m. breakfast.[32]

[31] *See Halderman v. Pennhurst State School and Hospital*, 446 F.Supp. 1295 (E.D. Pa. 1975). When institutionalized retarded children experience adult contact, it is almost exclusively for management, custodial or child-care purposes; only 4% of ward attendants' time is devoted to training and habilitation. Velt, *Interpersonal Interactions Between Institutionalized Retarded Children and Their Attendants*, 80 Am.J. Mental Defic. 535 (1976). One study notes that the practice of moving institutionalized juveniles and staff from one unit to another can be devastating; during a 3½ year period, at least 99 different day staff were on duty with the children being cared for by a total of 246 different adults. The children were moved at least twice and some as many as 18 times. Tizard, *The Role of Social Institutions in the Causation, Prevention and Alleviation of Mental Retardation*, Haywood, *Social-Cultural Aspects of Mental Retardation* (1970). *See* Klaber, *supra* note 22.

The "deprivation of liberty inherent in institutionalization" for young persons classified as mentally ill and mentally retarded is accurately summarized by the District Court:

> One expert testified to the "derailment from the usual course of one's life, the dreary regimen even in the most progressive hospitals, the extreme deprivation and limits" which are the effects of institutionalization. Institutions prevent persons from being exposed to normal community experiences and prevent individual growth. With respect to mentally retarded persons, these conditions may be rendered even more acute by the person's inability to protect himself against the dehumanizing effects of institutionalization. Finally, these effects appear to be the same regardless of whether the institution is state-operated or privately-operated; the crucial variable is size.[33]

The "powerful long-term effect on the individual's life" (990a) of institutionalization reverberates long after release from the facility.

[32] *Halderman v. Pennhurst State School and Hospital, supra* note 31, 446 F.Supp. at 1303 (citations omitted). Many other courts have found similar regimented and depersonalized conditions in institutions for the retarded across the country. *E.g., New York State Association for Retarded Children v. Rockefeller*, 357 F.Supp. 752 (E.D.N.Y. 1973), *modified*, No. 72-C-356/357 (E.D.N.Y., May 23, 1973), 393 F.Supp. 715 (E.D.N.Y. 1975) (approving consent order); *Horacek v. Exon*, 354 F.Supp. 71 (D. Neb. 1973); *Wyatt v. Stickney*, 325 F.Supp. 781 (M.D.Ala. 1971), 334 F.Supp. 1341 (M.D. Ala. 1971), 344 F.Supp. 373 and 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

[33] Opinion at 1070a.

Severe social stigma, self-stigmatization, job and license discrimination also result from the experience of commitment to mental institutions for the mentally ill and the retarded.[34] It is the fact of institutionalization, not the procedures used, which stigmatizes.[35] As

[34]Opinions at 795a, 1067a, 1077a-1078a. On stigma generally, *see Goffman, Stigma: Notes on the Management of Spoiled Identity* (1963). Regarding stigma and the mentally ill, *see, e.g.*, Testimony of Dr. Kandler at 574a-575a, Dr. Messinger at 622a, Dr. Feiner at 475a, Dr. Ingall at 596a and Dr. Miller at 705a; *In re Ballay*, 482 F.2d 648, 668 (D.C. Cir. 1973); *Lessard v. Schmidt*, 349 F.Supp. 1078 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974), *on remand*, 379 F.Supp. 1376 (E.D.Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), *on remand*, 413 F.Supp. 1318 (E.D.Wis. 1976); Braginsky, *et al., Methods of Madness: The Mental Hospital as a Last Resort* (1969). On the mentally retarded and stigma, *see Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania*, 343 F.Supp. 279, 293-295 (E.D.Pa. 1972); Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded* (1967); Braginsky & Braginsky, *Hansels and Gretels: Studies of Children in Institutions for the "Mentally Retarded"* (1971); Severance & Gasstrom, *Effects of the Label "Mentally Retarded" on Causal Explanations for Success and Failure Outcomes*, 81 Am. J. of Mental Def. 547 (1977). In one study of school children in the community, school teachers were found to have low expectancies of students labeled retarded; the teachers maintained these expectancies even when confronted with normal behavior and, in fact, misinterpreted actual behavior in response to their bias. Foster *et al., Expectancy and Halo Effects as a Result of Artificially Induced Teachers Bias*, 1 Contemporary Educational Psychology 37 (1976).

[35]"Unfortunately, there is a stigma being attached to being in a hospital, which would be another reason why all care ought to be taken before this type of drastic step be taken. I never heard the fact that a judge or attorney being involved in a proceeding increases that stigma." Testimony of Dr. Kandler at 574a-575a.

(continued)

the lower court found, this "stigma is imposed both outwardly, in that juveniles who have been in institutions encounter substantial obstacles in the community, and inwardly in that the self-image of the juvenile is almost severely damaged."[36]

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Non-institutional mental health care is not viewed in the same highly negative way as is institutional care:

> The lay public seems to adhere to a single operational definition of the mental patient. To the average man, a person becomes a mental patient only when he enters a psychiatric hospital.

Rabkin, *Public Attitudes Toward Mental Illness: A Review of the Literature*, 10 Schizophrenia Bull. 9 (1964). This deprecating label, which applies for an indefinite period after discharge from the institution, is not in general used for psychiatric patients seen only in private consultation or clinics. *Id.*

[36]Opinion at 1067a (notes omitted). The public fears, distrusts, dislikes and excludes those persons labeled "mental patients." Rabkin, *supra* note 35. The prejudice against mental illness results not simply from an ignorant or biased public but, in part, from the activities of psychiatrists. Schwartz & Schwartz, *Reducing the Stigma of Mental Illness*, 38 Diseases of the Nervous System 101 (1977). Numerous studies document the self-stigmatization which lowers self-esteem and encourages aberrant behavior in both mentally ill and mentally retarded institutionalized persons. *E.g.*, Lindsey, *Patient Inquiry Into Mental Hospitalization: A Quantitative Analysis*, 10 Adolescence 337 (1975); Bouliew, *Do Institutions Maintain Retarded Behavior*, 9 Mental Retardation 36 (1971). Commissioner Glenn testified that, with regard to those persons committed as retarded, "the stigma really hurts the person's later integration into the community. * * * The discrimination that is placed on these people is quite traumatic." (991a). *See also* authorities cited *supra* at note 34.

B. Liberty Interests Under the Fourteenth Amendment Are Implicated by the Commitment of Young Persons to Mental Institutions.

Mental commitment is generally considered a deprivation of liberty under the Fourteenth Amendment and the states are required to provide substantial procedures to protect persons from erroneous commitment to mental institutions:

> There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the state cannot accomplish without due process of law. Specht v. Patterson, 386 U.S., at 608, 18 L.Ed.2d 527, 87 S.Ct. 1428 (1967). Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding.

O'Connor v. Donaldson, 422 U.S. 563, 580 (1975) (Chief Justice Burger, concurring). This Court has consistently upheld claims by inmates of mental institutions to hearing and other procedures protective of their constitutional rights. *Baxstrom v. Herold*, 383 U.S. 197 (1966); *Specht v. Patterson*, 386 U.S. 605 (1967); *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *McNeil v. Director, Patuxent Institution*, 407 U.S. 245 (1972).[37]

[37]The lower federal courts have uniformly held that due process mandates procedures similar or identical to those required by the District Court here. *E.g., Lessard v. Schmidt, supra* note 34; *Lynch v. Baxley*, 386 F.Supp. 378 (M.D.Ala. 1974); *Bell v. Wayne County*, 386 F.Supp. 1085 (E.D. Mich. *(continued)*

The Court's deep concern that due process be afforded to the mentally disabled is by no means newly conceived. Sixty years ago, in *Chaloner v. Sherman*, 242 U.S. 455 (1917), a challenge was made to state mental incompetency procedures. Speaking for a unanimous court, Justice Brandeis declared:

> As the plaintiff had notice and opportunity to be heard at each stage of the proceedings, the essential elements of due process of law were fully met, and the court had jurisdiction to enter that order.

242 U.S. at 455. *See also Dexter v. Hall*, 82 U.S. 9, 25 (1872) (". . . a lunatic needs more protection than a minor." "Both such classes of persons are regarded as under the protection of the law.").

In an attack on Minnesota mental commitment procedures, this Court upheld a statute which provided for a hearing, counsel, confrontation, a record and the right to appeal. *Minnesota ex rel. Pearson v. Probate Court of Ramsey County*, 309 U.S. 270, 276-277 (1940) ("We fully recognize the danger of a deprivation of due process in proceedings dealing with persons charged

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1974); *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F.Supp. 966 (M.D. Pa. 1971); *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968); *In re Ballay, supra* note 34; *In re Basso*, 299 F.2d 933 (D.C. Cir. 1962); *In re Barnard*, 455 F.2d 1370 (D.C. Cir. 1971); *Sarzen v. Gaughan*, 489 F.2d 1076 (1st Cir. 1973); *Kendall v. True*, 391 F.Supp. 413 (W.D. Ky. 1975); *Barry v. Hall, supra* note 21; *Doremus v. Farrell*, 407 F.Supp. 509 (D. Neb. 1976); *Suzuki v. Quisenberry*, 411 F.Supp. 1113 (D. Hawaii 1976); *Suzuki v. Alba*, 438 F.Supp. 1106 (D. Hawaii 1977).

with insanity or, as here, with a psychopathic personality as defined in the statute.").[38]

In *Specht v. Patterson*, 386 U.S. 605 (1967), the Court rejected the notion that individual rights can be bypassed by labeling a procedure "civil" rather than "criminal."[39] Discussing mental commitment proceedings under the Colorado Sex Offender Act, the Court held, "These commitment proceedings whether denominated civil or criminal are subject both to the Equal Protection Clause of the Fourteenth Amendment as we held in *Baxstrom v. Herold*, 383 U.S. 107, 86 S.Ct. 750, 15 L.Ed.2d 620, and to the Due Process Clause." *Specht*, 386 U.S. at 608.[40]

[38] *See Logan v. Arafeh*, 356 F.Supp. 1265 (D. Conn. 1972), *aff'd mem. sub nom. Briggs v. Arafeh*, 411 U.S. 911 (1973), where the district court upheld a statute noting that a "judicial decision after receiving evidence from a general physician and a psychiatrist in an adversary hearing is fully adequate to safeguard against involuntary commitment through mistake or abuse." 346 F.Supp. at 1270. *Logan* permitted a delay in hearings for people certified as "dangerous;" the Pennsylvania statutes here require only a finding of "in need of care or observation," 1966 Act, or "in need of treatment." 1976 Act.

[39] The irrelevance of civil-criminal labels was the basis for the decision in *Giacco v. Pennsylvania*, 382 U.S. 399 (1966), where an acquitted criminal defendant challenged a state law permitting a jury to assess costs against him. Pennsylvania courts characterized the statute as "of a civil character." Noting that it "provides the State with a procedure for depriving an acquitted defendant of his liberty and his property," the Court held that Fourteenth Amendment "protection is not to be avoided by the simple label a State chooses to fasten upon its conduct or statute." 382 U.S. at 402.

[40] The due process required in mental commitments today is not unlike that described by Blackstone. Before a person could be

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The pervasive concern has been that no person may be caused to suffer a loss of liberty—for whatever reason—without stringent decision-making requirements designed to minimize the ever-present risk of error and to assure proper disposition of the case.[41]

The defendants, invoking the "family's right of privacy" and "the sanctity of parental responsibility,"[42] maintain that a young person's constitutional right to

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declared retarded ("an idiot"), a writ *de idiota inquirendo* would be filed and "tried by a jury of twelve men;" a declaration that one was mentally ill (a "lunatic") did not occur until after the lord chancellor, "upon petition or information, grants a commission in the nature of the writ *de idiota inquirendo*, to inquire into the party's state of mind." Blackstone, *Commentaries on the Laws of England* 305 (Wendell, ed., 1852). In Blackstone's day, "The legislature, to prevent all abuses incident to such private custody, hath thought proper to interpose its authority, by statute [citation omitted] for regulating private mad-houses." *Id.* As discussed more fully below, *infra* at §II.B., from its earliest Constitution and laws until recently, Pennsylvania required judicial proceedings for mental commitments of all persons, regardless of age, to mental institutions, whether publicly owned or not.

[41] Discussing mental commitments, Wigmore declares, "In such proceedings, *nothing can excuse the judge from personally hearing and examining the party* to be committed" (emphasis in original) because of the extreme risk of an improper commitment:

> No greater cruelty can be committed in the name of the law. And any statute which makes such a result possible, by refusing to let a sane person appear before the judge and plead his own case and hear the witnesses against him, is a thoroughly bad statute.

5 Wigmore, *Evidence* §1400 (3d ed., 1940) (footnote omitted).

[42] Brief for Appellants at 28.

liberty is not implicated at all in mental institutionalization. Finding no support in any previous decision of this Court, this conclusion misconceives constitutional doctrine which full recognizes the applicability of the central meaning of liberty—freedom from physical confinement—to young persons, while setting variable limits on other asserted liberties of minors under the Fourteenth Amendment.

The "power of the state to control the conduct of children reaches beyond the scope of its authority over adults." *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944). For example, young persons may be required to receive a basic education in school, *Wisconsin v. Yoder*, 406 U.S. 205, 213 (1972), and may be limited in their access to objectionable material. *Ginsberg v. New York*, 390 U.S. 629 (1968). In addition, parents and guardians have the right to direct the upbringing of their children in their early and formative years. *E.g., Pierce v. Society of Sisters*, 268 U.S. 510 (1925).

Two controlling principles emerge from the Court's decisions regarding parents and children. Where the state unreasonably intrudes into the family's domain and thereby jeopardizes the family's function and strength as the primary socialization mechanism, the state's intrusion will be struck down. *See Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Wisconsin v. Yoder*, 406 U.S. 205 (1971). In precisely parallel fashion, where parental decisions unreasonably jeopardize the young person's "opportunities for growth into free and independent well-developed men and citizens," governmental intrusions into the family will be upheld. *Prince v. Massachusetts*, 321 U.S. 158, 165 (1944). In *Prince*,

the Court upheld restrictions on the rights of guardians and supported certain regulation of family interests, explaining:

> But the family itself is not beyond regulation in the public interest, as against a claim of religious liberty. [citations omitted] And neither rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth's well-being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways.

Id. at 166 (notes omitted). And more recently, in *Wisconsin v. Yoder*, 406 U.S. 205 (1972), limitations on parental powers continued to receive approval; such regulation is proper "if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens." *Id.* at 234.

The extent of control over juveniles by parents and guardians is broad enough to provide appropriate deference to the "importance of the family," *Stanley v. Illinois*, 405 U.S. 645, 651 (1972), but narrow enough to protect the independent personal interests of the most powerless of the family's members.[43] The presence of "family interests" in a case does not efface the interests of the child as an individual.

Other courts have uniformly agreed that, in the parent-child context, the law as *parens patriae* must

[43]Dr. Feiner testified that ". . . the child has some intrinsic vulnerability based upon the fact the child is dependent to begin with, the child is more controllable in certain ways, the child is also often a newcomer to the setting, the last to be present in this little system . . ." (472a).

protect the welfare of children, an interest to which that of parents must yield.[44] The key consideration in all these cases is that society has an interest—independent of parents—in assuring the welfare of children.

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[44]The issue arises most often in custody cases. *E.g., Holtsclaw v. Mercer*, 145 F.2d 388 (D.C. Cir. 1944); *Langan v. Langan*, 150 F.2d 979 (D.C. Cir. 1945). *See In re Stuart*, 114 F.2d 825 (D.C. Cir. 1940) (right of parents to control upbringing of children not absolute); *Newton v. Burgin*, 363 F.Supp. 782 (W.D.N.Ca. 1973) (Three-Judge Court), *aff'd*, 414 U.S. 1139 (1974) (parental constitutional right to control children can be limited by statute).

Among the many situations in which parental "rights" and "powers" have been held properly restricted are juveniles curfews, *Bykofsky v. Borough of Middletown*, 401 F.Supp. 1242 (M.D. Pa. 1975), *cert. den.*, __ U.S. __ ; drinking age laws, *Republican College Council of Pennsylvania v. Winner*, 357 F.Supp. 739 (E.D.Pa. 1973); sex education, *Cornwell v. State Board of Education*, 314 F.Supp. 340 (D. Md. 1969), *aff'd*, 428 F.2d 471 (8th Cir. 1970), *cert. den.*, 400 U.S. 942 (1970); blood transfusions, *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769 (1952), *cert. den.*, 344 U.S. 824 (1952); corporal punishment, *Ware v. Estes*, 328 F.Supp. 657 (N.D.Tex. 1971); visitation, *Comm. ex rel. Heston v. Heston*, 98 A.2d 477, 173 Pa.Super. 260 (1953); approval of personal injury settlements, *Rafferty v. Rainey*, 292 F.Supp. 152 (E.D. Tenn. 1968); abortion, *In re Smith*, 295 A.2d 238, 16 Md.App. 209 (1972) (mother cannot compel daughter to submit to abortion); organ transplants, *Hart v. Brown*, 289 A.2d 385, 29 Conn.Sup. 368 (1972); sterilization, *Frazier v. Levi*, 440 S.W.2d 393, 394 (Civil App. Tex. 1969); and monetary matters. *Ellis v. Massenberg*, 126 N.C. 129, 35 S.E. 40 (1900) (action to set aside deed); *White v. Osborne*, 251 N.C. 56, 110 S.E.2d 449 (1959); *Babcock v. Fisk*, 327 Mich. 72 (1950) (control of publicly raised funds).

The contrary assertion of defendants that, except in life-or-death situations, parental wishes always prevail over asserted interests of children, is totally unsupported in law or reason and must be rejected.

Where constitutional rights are at stake, and family interests are not implicated, this Court has recognized claims by young persons asserting liberties in various substantive and procedural realms. *E.g., Goss v. Lopez*, 419 U.S. 565 (1975) (suspension from public school); *Tinker v. Des Moines Independent Community School District*, 393 U.S. 503, 506-507 (1969) (First Amendment right to political expression);[45] *Erznoznik v. City of Jacksonville*, 422 U.S. 205, 212-214 (1975) (First Amendment interest in flow of communicative material); *Ingraham v. Wright*, 430 U.S. 651, 672-674 (1977) (Due Process right to be free from unjustified intrusions on personal security); *Carey v. Population Services International*, 431 U.S. 678 (1977) (access to contraceptives). In these cases, while the *extent* of minors' liberty interests was held subject to possible limitation, the *existence and nature* of those liberty interests, similar to those of adults, was nevertheless recognized.

One liberty interest of young persons which has repeatedly been identified by this Court as implicated by the Fourteenth Amendment is the right to be free from physical confinement. *See Haley v. Ohio*, 332 U.S. 596, 601 (1948); *Gallegos v. Colorado*, 370 U.S. 49, 54 (1952); *Kent v. United States*, 383 U.S. 541 (1966); *In re Gault*, 387 U.S. 1 (1967); *In re Winship*, 397 U.S. 358 (1970); *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971); *Breed v. Jones*, 421 U.S. 519 (1975). These cases do not admit of any question as to the extent of the juvenile's liberty interest in not being confined, for whatever purpose, in an institution.

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[45]The students' ages in *Tinker* were 8, 11, 13, 15 and 16. 393 U.S. at 516.

There is no suggestion in these decisions that parental endorsement of a decision to separate the young person from the home and to confine him or her in an institution somehow nullifies the minor's Fourteenth Amendment interests.[46]

The *Haley-Gault-Breed* line of cases are emphatic that a constitutional liberty is discerned even if the purpose of the confinement is "clinical"[47] treatment or "to save the child:"[48]

> Regardless of the purposes for which the incarceration is imposed, the fact remains that it is incarceration. The rehabilitative goals of the system are admirable, but they do not change the drastic nature of the action taken.

Breed v. Jones, supra, 421 U.S. at 530, n. 12.[49]

[46]In *Ginsberg v. New York*, 390 U.S. 629 (1968), the Court held that the Constitution supports the parental "claim to authority *in their own household*" to direct the rearing of children. *Id.* at 639 (emphasis added). This suggests that parental authority may not be absolute when the young person is excluded from the household.

[47]*In re Gault*, 387 U.S. 1, 16 (1967).

[48]*In re Winship*, 397 U.S. 358, 365-366 (1970).

[49]A case strikingly on point is *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968), where a nine year old child was committed to a training school for the feeble-minded and epileptic:

> But, like *Gault*, and of utmost importance, we have a situation in which the liberty of an individual is at stake, and we think the reasoning in *Gault* emphatically applies. It matters not whether the proceedings be labelled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training for a feeble-minded

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It would have made no constitutional difference if Gerald Gault's mother had favored his confinement for making an obscene telephone call or if Gary Steven Jones' mother had preferred that he be tried as an adult for robbery.

The deprivation of liberty and other harms which flow from commitment are accompanied by the serious and irreparable stigma described above. Such injury to standing, reputation and one's future functioning as a citizen, coupled with the deprivation of physical freedom, implicates the young persons' liberty interests under the Fourteenth Amendment. *See Wisconsin v. Constantineau*, 400 U.S. 433 (1971); *Paul v. Davis*, 424 U.S. 693 (1976).[50]

Without question, the Fourteenth Amendment liberty interests of young persons are affected when

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> or mental incompetent—which commands of the constitutional safeguards of due process.

396 F.2d at 396. *See Saville v. Treadway*, 404 F.Supp. 430 (M.D.Tenn. 1974); *Kidd v. Schmidt*, 399 F.Supp. 301 (E.D. Wis. 1975).

[50]*See* Note, *Developments in the Law, supra* note 21, 87 Harv. L. Rev. at 1198-1201. In *Gary W. v. Louisiana*, the court concluded:

> Involuntary institutional confinement of any person, adult or child, entails a "massive curtailment of liberty," Humphrey v. Cady, 1972, 405 U.S. 504, 509. Such institutionalization stigmatizes those confined and may at times exceed even criminal incarceration in its destructive impact on an individual's personal freedom.

437 F.Supp. 1209, 1216 (E.D. La. 1976) (commitment of children to mental institutions).

they are indeterminately confined in mental institutions.[51]

C. The Constitutional Rights of Young Persons in the Mental Institutionalization Process are not Overcome by Parental Application for Commitment.

The Facts Regarding Families Seeking Commitment of "Mentally Ill" Minors

As the lower court's unchallenged factual findings[52] and the record in this litigation shout forth, applications for commitment of young persons to mental institutions are not the expression of calm, rational, reliable, informed conflict-free parents and guardians. On the contrary, the expert witnesses for all parties

[51]This conclusion is reached in a persuasive recent analysis of the question. Teitelbaum & Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application*, 12 Family Law Quarterly 153 (Fall, 1978).

Defendants raise the spectre of application of the decision in this case to provision of services in the community in non-institutional home-like settings. Brief for Appellants at 34, n. 17. The complaint, the lower court's opinions, findings and order, however, deal only with institution-based residential care as distinguished from community-based care. Plaintiffs make no claim regarding non-institutional care in this case.

[52]Opinion at 1060a-1070a. The defendants do not challenge any factual findings on appeal as clearly erroneous. *See* Fed. R. Civ. Pro. 52(a); *United States v. United States Gypsum Co.*, 333 U.S. 364, 394-395 (1948) (stating rule); *Graver Tank & Mfg. Co. v. Linde Air Products Co.*, 336 U.S. 271, 274-275 (1949) (application of "clearly erroneous" test to findings based largely on expert testimony).

agreed that families seeking commitment of allegedly handicapped children are characterized by severe stress, disharmony and dislocation.[53] The problems of children are a function of intrafamilial problems and exist in a context of a weakened family structure with conflict overtly expressed.[54] The juvenile behavior which precipitates institutionalization may be provoked by the parents; there are also many cases where the child may be driven to such behavior by the conflicts at home.[55]

[53]*See* testimony of Dr. Kandler at 543a, 553a-554a, 570a-571a; Dr. Ingall at 588a-590a, 601a; Dr. Messinger at 616a-619a; Dr. Tashjian at 651a-652a, 656a-657a; Dr. Masterson at 727a-728a, 733a-734a. *E.g.*, Alanen, *The Family in the Pathogenesis of Schizophrenia and Neurotic Disorders*, 24 Acta Psychiatrica et Neurologica Scandinavica, Suppl. 189 (1966); Lidz, *et al., Schizophrenia and the Family* (1966); Lidz, *et al., The Intrafamilial Environment of Schizophrenic Patients. II. Marital Schism and Marital Skew*, 114 Amer. J. of Psychiatry 281 (1957). *See generally*, Fleck, *Some Basic Aspects of Family Pathology*, in Wolman, ed., *Manual of Child Psychopathology* 189 (1972).

[54]*See* testimony of Dr. Ingall at 588a, 610a; Dr. Messinger at 616a-619a; Dr. Masterson at 733a-734a; Dr. Tashjian at 668a-669a; Dr. Feiner at 467a-469a, 471a-472a, 501a-502a; Wohlman, *Family Dynamics and Schizophrenia*, 6 J. of Health and Human Behavior 147 (1965); Weeks & Mack, *The Child*, in Nicholi, ed., *The Harvard Guide to Modern Psychiatry* (1978).

[55]*See* testimony of Dr. Masterson at 733a; Dr. Feiner at 468a. One court which noted the possibility that a "breakdown in parental control" of a child could result from failings in the parent rather than in the minor, required inquiry into "intra-family parent-child conflict." *In re Henry G.*, 28 C.A.2d 276, 284-285, 104 C.R. 585 (1972), describes the issue in this way:

> The Fourth Commandment is still an integral part of the beliefs of our society. It is one thing, however, to say that a teen-age minor has struck the parent—it is another thing if that striking is done in self-defense and in response to traumatic situations initiated by the parent.

Parents will often seek to institutionalize children for improper reasons. This stems from honest mistakes, ignorance, lack of awareness of alternatives to institutionalization, lack of community resources or sometimes from malice or ill will.[56] In a significant number of cases, the parental purpose of bringing a child to treatment "has been to accuse him, to punish him, to separate him from the home. The motivation is not always good."[57]

Experts for both plaintiffs and defendants were in agreement that parents are not particularly good observers of children's behavior and symptoms and, especially with the high feelings that run in these situations, parents are not reliable sources of factual information about the child and his or her behavior.[58] Parents who bring their child to professionals seeking care "can't be objective reporters" of the behavioral background of the child.[59] Parents often exaggerate and misinterpret the actions of their children and may often react antagonistically to their children, in these cases.[60]

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[56] *See* testimony of Dr. Kandler at 543a, 553a-554a; Dr. Miller at 685a.

[57] Testimony of Dr. Ingall at 601a.

[58] *See* testimony of Dr. Masterson at 733a; Dr. Kandler at 543a; Dr. Ingall at 592a, 601a; Dr. Sugar at 401a.

[59] Testimony of Dr. Feiner at 478a. *See* testimony of Dr. Messinger at 623a-624a.

[60] Testimony of Dr. Sugar at 404a-408a. Young persons are often committed not to resolve problems but to avoid them:

> From the point of view of the family, the primary function of scapegoating is that it permits the family to maintain its solidarity. In all the disturbed families, there were very

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The roster of Haverford State Hospital plaintiffs committed under the challenged statute is a complete one as of the time suit was filed; no selection, random or otherwise, was made (945a). Every one of these young persons comes from a disrupted, chaotic or conflicted home. For example, Kevin S. was physically abused by his schizophrenic mother who had lied to obtain her own admission to a mental hospital to give birth to him. Richard S.' mother did not have him home until he was two and he stayed with her only two years. James Paul M. lived with just his father, his mother having died not long before his commitment. Edward B.'s parents admitted tricking him into the hospital. Richard C.'s father had a drinking problem.

William B's parents separated during his infancy; he was committed after he began living with his father, stepmother and stepbrothers. According to hospital records, his life with family members subjected him to extreme inconsistency, disorganization and lack of structure. Similarly, Francis B. comes from a disorganized family which rejected him (the records refer to "the almost total rejection of Frankie by everyone in his

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> severe strains which continuously threatened to disrupt the family. . . . By focusing on one particular child, the families were able to encapsulate problems and anxieties which could potentially disrupt various family processes. There seemed to be an added solidarity between the parents who stood united against the problem child. The fact that it is a child who is disturbed permits the parents to continue to perform the tasks necessary for household maintenance.

Vogel & Bell, *The Emotionally Disturbed Child as the Family Scapegoat*, in *A Modern Introduction to the Family* 125 (1968). *See also*, Laing & Esterson, *Sanity, Madness and the Family* (1964).

family"). There is a question of physical abuse in his case; this plaintiff "could no[t] do right in parents' eyes."

Maria L.'s parents were saved from divorce only by the birth of a new child. Her father drinks and won't assume any responsibility for the four children in the family. Her mother, on the brink of mental breaddown, several times tried to choke Maria.Thomas W.'s mother and stepfather, involved in an unstable marriage, were arrested after a severe beating of Thomas which resulted in his hospitalization. Social service agencies have cared for him since.

When these family dynamics are viewed in the context of the alleged behaviors which precipitate the request for commitment, "conflicts between the concerns and interests of the parents, and the best interests of the child frequently arise. . . ."[61]

The Facts Regarding Families Seeking Commitment of "Retarded" Minors

Stereotypes regarding the retarded and their mental institutionalization are tragically hardened and erroneous. A person's level of retardation does not predetermine his or her need for institutionalization.[62]

[61]Opinion at 1068a. *See* authorities cited *supra* at notes 53, 54 and 60. In a recent study of 587 inpatient psychiatric admissions of children over a five year period, it was found that low functioning psychotic children are admitted to psychiatric hospitals not because of a change in the child's behavior but because of the particular stress on the family. Hagamen, *Family Support Systems: Their Effect on Long-Term Psychiatric Hospitalization in Children*, 16 J. Amer. Acad. Child Psychiatry 53 (1977).

[62]Testimony of Commissioner Glenn at 997a.

While degree of intellectual and physical impairment is a factor in determining institutionalization of retarded individuals, it clearly does not stand alone nor is it necessarily the most important. Other factors are the degree of family disorganization, demographic characteristics, parental attitudes toward childrearing and mental retardation, availability of community resources, and the professional philosophies of those consulted for advice.[63] "Professional philosophies influence decisions because patient oriented clinicians are more likely to give first priority to factors they consider advantageous to the child, whereas family oriented clinicians are more likely to base their recommendations on those which they assume to be best for the family."[64]

Parents of retarded persons often resort to seeking institutionalization as a means of securing relief from severe physical and emotional strains and because of a lack of finances and adequate community resources:[65]

> However, if these parents are "given honest information about residential and community alternatives and time to reflect," most of them

[63]*E.g.*, Eyman, *et al., Factors Determining Residential Placement of Mentally Retarded Children*, 76 Amer. J. of Mental Deficiency 693 (1966); Gralicker, *et al., A Study of Factors Influencing Placement of Retarded Children in a State Residential Institution*, 69 Amer. J. of Mental Deficiency 553 (1965).

[64]Eyman, *op. cit. supra* note 63, at 697.

[65]*See, e.g.*, Justice, *et al., Problems Reported by Parents of Mentally Retarded Children—Who Helps?*, 75 Amer. J. of Mental Deficiency 685 (1971). For a sensitive discussion of what parents face, see testimony of Glenn at 1001a-1005a. *See also* Teitelbaum and Ellis, *supra* note 51.

> "come to realize that the placement in most institutions means placing a lid on the child's potential by consigning him to custodial care—sometimes humane but often inhumane by anyone's standards. Most good residential schools (offering education and training as well as care) are extremely expensive. Most state institutions are still little more than warehouses which 'store' people."[66]

Inappropriate and unneeded institutionalization is often the unintended result.

The three named plaintiffs committed as retarded include two who are only moderately retarded. George S., abandoned by his parents, was institutionalized after a foster mother became ill and a second foster home became too crowded. Gina S., was placed out of the family home when her parents divorced and, three years later, was taken by her mother directly from the county infants' home to the mental institution. Both parents of Nancy Louise D. were alcoholic and mentally retarded; the county welfare department placed her first in foster care and then into the institution.

The only evidence on these matters is the expert testimony of Linda Glenn, Assistant Commissioner for Mental Retardation, Department of Mental Health, Commonwealth of Massachusetts (972a-1049a). Her testimony, unchallenged by the defendants, confirms the trying situation faced by families of the retarded and those classified as retarded. The District Court was surely correct in these factual findings and conclusions:

[66]Hobbs, *The Futures of Children* 142 (1975) (citation omitted).

[67]Testimony of Commissioner Glenn at 997a-1004a.

> Similarly, parents of mentally retarded children are frequently subject to community pressure to institutionalize their children. Other personal pressures, such as the parents' own emotional difficulties in dealing with the mentally retarded child, as well as the financial problems of providing necessary care, may cause a parent to institutionalize a mentally retarded child although that course is not in the child's best interests. Finally, the parents simply may not be aware of less drastic alternatives to institutionalization (1069a, notes omitted).

In the case of the mentally retarded and their parents, when the question is institutionalization, there is no identity of interests which may be presumed.

The Test in the Danforth Case Accommodates the Interests Involved

The decision of the lower court that parents' and guardians' interests do not negate the rights of young persons in the mental commitment context is manifestly correct.[68] Where parents and guardians seek

[68]The District Court and defendants approach the issue as one of parental power to "waive" minors' rights. While the result is the same, plaintiffs do not believe that the constitutional concept of waiver is relevant here. There is no case in which parents have been found to have waived or not to have waived the constitutional rights of their children. *Gault* discussed the issue of waiver with the Court noting that problems might arise "depending on the age of the child and the presence and competence of the parents." 387 U.S. at 55. *See Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968) (issue described but not decided).

In plaintiffs' view, the critical question is whether juveniles can be deprived of their rights where parents and guardians assert

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confinement of young persons in mental institutions, there are no significant interests which overcome the right to minimal due process protections.

The factual and legal status of parent-child relations in mental commitment is summarized by the District Court in these telling words:

> There may be instances where the congruence between the parents' interests and those of the child assure that the parents will arrive at a decision based upon the best interests of the child. The evidence in this case overwhelmingly demonstrates that, due to the substantial potential for conflict between the interests of the parent and the child, this is not such a situation.[69]

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contrary and divergent rights. As discussed in the text *infra*, this approach is consistent with that followed by this Court in the parental consent to abortion cases where an inquiry was not made into parental competence to "waive" the rights involved.

Should the Court undertake to consider the waiver issue, plaintiffs submit that parental application for state commitment without more cannot be considered a valid waiver of a young person's rights to counsel and an opportunity to be heard. A waiver of constitutional rights must be made "voluntarily, knowingly and intelligently." *Miranda v. Arizona*, 384 U.S. 436 (1966). There must be an 'intentional relinquishment or abandonment' of a fully known right." *In re Gault*, 387 U.S. 1, 42, quoting *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938).

A valid waiver may not be presumed from the silence of the person involved. *Miranda v. Arizona, supra; In re Gault, supra*, 387 U.S. at 34. In cases involving juveniles, even apparent waivers have been invalidated. *E.g., Haley v. Ohio*, 332 U.S. 596, 601 (1948).

[69]Opinion at 1077a (note and citations omitted). As the District Court indicates, *id.* at n. 44, this case does not present the difficult question of whether parents would have the right to "waive" the constitutional rights of their children, absent seriously conflicting and divergent interests.

The required constitutional analysis refutes defendants' argument that parents must be "in control of the situation" and permitted to waive young persons' Fourteenth Amendment rights. Brief for Appellants at 38.

In *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), finding a protected liberty interest for minors, the Court proceeded "to examine whether there is any significant state interest in conditioning an abortion on the consent of a parent or person in loco parentis that is not present in the case of an adult." *Id.* at 75. This is the test which must be applied in the case at bar.

A direct and persuasive response to *Danforth* is that, as demonstrated above, the constitutional interest in freedom from physical confinement without due process admits of no exceptions. No asserted state interest in any previous decision of this Court has overcome this "liberty," no matter how rehabilitative or treatment-oriented the institution of confinement has been. Those cases, however, did not involve a parent or guardian acting to secure confinement.[70]

The state here, citing no decision of this or any other court, makes a succinct argument that the state's interest is parental autonomy, expressed by medically-

[70]The concurrence of a doctor or hospital in the action is of no constitutional significance under the *Danforth* test. Under *Danforth* and *Bellotti v. Baird*, 428 U.S. 132 (1976), agreement by a doctor to perform a medical procedure does not diminish or negate the asserted constitutional interest (in those cases, the interest of the parents). Further, as the decisions of this and other courts demonstrate, reliance on medical certification to justify mental commitment, absent a hearing and other protections, will not satisfy due process.

advised deprivation of young persons' liberty. Brief for Appellants at 37-38.

Such an argument was expressly rejected in *Danforth* where the young person and parent "are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure." 428 U.S. at 75. "Any independent interest the parent may have . . . is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant." *Id.* Likewise, any parental right to obtain mental health care for a child[71] is no more weighty than the liberty right of a child proposed for

[71]Mental institutionalization can hardly be considered run-of-the mill general medical care. No court or legislature has ever considered it such. *See, e.g.*, discussion of Pennsylvania legal history, *infra* at §II.B., and cases cited at 36-38 *supra*. The lower court explained:

> Unlike other kinds of medical treatment, a substantial stigma attaches to institutionalize. This stigma coupled with the substantial danger of error in the diagnosis of mental illness and mental retardation, and the greater potential for long-term loss of liberty create a situation substantially different from the treatment of other parent-child medical conditions. Furthermore, we perceive little or no parent-child conflict in the decision to give or withhold other kinds of medical treatment since a parents' interests are more likely to be similar to the best interests of the child.

1077a-1078a. To the extent that mental health care is considered similar to other medical care, the right of parents to impose it must be considered in light of the risks to the child. *See, e.g., Jehovah's Witnesses in State of Washington v. King County Hospital Unit No. 1 (Harborview)*, 278 F.Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968), *rehearing den.*, 391 U.S. 961 (1968) (parents sued on "right to decide what medical treatment they will accept for their children;" blood transfusion case). *See also* cases cited *supra* at n. 44.

institutionalization. It is the "absolute limitation on the minor's right," 428 U.S. at 90 (Stewart, J. and Powell, J., concurring), with no provision for "judicial resolution of any disagreement," *id.*, which causes the greatest risk of harm to the juvenile and involves the least benefit to legitimate state interests. *See Bellotti v. Baird*, 428 U.S. 132 (1976).

Under the *Danforth* test, a countervailing significant state interest must be established by more than the unsubstantiated declaration of its existence. *Carey v. Population Services International*, 431 U.S. 678 (1977). Here, the record provides no support whatsoever for the bare assertion of a "parental autonomy" interest in appellants' brief.

Other possible rationales for differentiating between the rights of young persons and adults are neither asserted by the defendants nor present in these circumstances.[72]

The critical question raised by *Danforth* is not *"when rights conflict, which are paramount?"* but *"when presumed common interests in fact diverge, how can each be accommodated and protected?"* There is a

[72]For example, the Court has on occasion looked to minors' vulnerability to harm and their lack of mature judgment in making decisions for themselves. *See, Prince v. Massachusetts*, 321 U.S. 158, 169 (1944); *Ginsberg v. New York*, 390 U.S. 629, 636-637, 649-650 (1968); *Danforth, supra*, 428 U.S. at 102 (Stevens, J., concurring in part and dissenting in part); *Carey, supra*, 431 U.S. at 693, n. 15.

The state interest in assuring emergency mental health care for young persons is protected by the District Court's denial of a pre-commitment hearing and allowance of temporary detention initiated by parents or guardians without a hearing (800a-801a, 1092a).

continuum of decisions made by parents and guardians regarding their wards. At one end are constitutionally trivial and intra-familial issues (what color shirt to wear, what friends to allow into the home) in which there is little, if any, potential harm to the child. Along the continuum, parental powers are met with limits as their interests and desires diverge from those of young persons, in whom the state has an interest (*e.g.*, compulsory school attendance, vaccinations, First Amendment limits). As the parents' claims threaten to risk or unduly interfere with the child's (abortion, blood transfusions), the divergence becomes so great that the parents' assertion of rights is not permitted to overshadow the social necessity of protecting young persons' independent interests. At the extreme end of the continuum are actions which society prohibits entirely as between parents and children (incest, physical abuse, neglect).[73]

When viewed in terms of its nature and potential for harm, mental institutionalization—whether the commitment is erroneous or not—is an event near the end of the continuum at a point where the "parental autonomy" claims are properly muted to the extent necessary to protect the "liberty" claims of the child who is being removed from the home and placed in an institution. Therefore, following the reasoning in other cases where the independent rights of minors have been protected in the absence of a guardian with common

[73]For another extreme situation, in which parents were limited in their right to remove a child from the home, *see Respublica v. Keppelle*, 2 U.S. 197 (Pa.Sup.Ct.), holding that a parent could not bind a child out as a servant.

non-divergent interests,[74] the District Court held that

[74]*See, e.g.*, cases cited *supra* at note 44; *Jehovah's Witnesses in State of Washington v. King County Hospital Unit No. 1 (Harborview)*, 278 F.Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968), *rehearing den.*, 391 U.S. 961 (1968) (court rejected parental "right to decide what medical treatment they will accept for their children" and "right to decide what medical treatment they will accept for their children" and "right to family privacy" in class action by parents); *Marsden v. Commonwealth*, 227 N.E.2d 1 (Mass. 1967) (child does not have adequate independent representation from parent where parent is complainant in stubborn child proceeding, although parent may have child's best interests in mind); *A.L. v. G.R.H.*, 325 N.E.2d 501 (Ind.App. 1975) (parent lacks power to secure sterilization of son, despite sincere belief in benefits of procedure). In a recent case holding that parents may not admit retarded children to a private hospital for sterilization, absent a hearing, the *Danforth* analysis suggested here was made. *Ruby v. Massey*, 452 F.Supp. 361 (D. Conn. 1978). A court's comments in a civil rights suit by institutionalized retarded children illustrates the approach in these cases:

> I cannot be insensitive to the probability that the interests of the parents may conflict with those of the children residing at the Beatrice State Home. While the parents in all good conscience may desire one remedy, or a specific type or style of treatment for their children, it would not necessarily be in the best interests of the children. Therefore, it seems to me that a discreet course would be to provide for the appointment of a guardian ad litem, who would not displace the parents as representatives of the plaintiffs but would be alert to recognize potential and actual differences in positions asserted by the parents and positions that need to be asserted on behalf of the plaintiffs.

Horacek v. Exon, 354 F.Supp. 71, 74 (D. Neb. 1973).

This Court has had experience with cases in which the property rights of minors have been protected by representation independent of the guardian. *Insurance Company v. Bangs*, 103 U.S. 435 (1880); *United States v. Dunn*, 268 U.S. 121 (1925); *Clarke v. Clarke*, 178 U.S. 186, 193-195 (1900). *See also United*

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"parents may not waive the constitutional right of their child not to be deprived of liberty without due process of law." (1086a).[75]

D. Reliance Upon Psychiatrists and Other Professionals to Authorize Commitment is Misplaced.

Although maintaining that parents must be "in control" of the commitment of young persons to mental institutions, defendants point to the "joint decision" by parents and physicians as a fail-safe that sufficiently protects the interests of the plaintiffs. Examination of the relevant law and facts reveals the phantom character of this asserted protection.

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States v. Equitable Trust Company of New York, 283 U.S. 738 (1931) (in lower courts, one court-appointed guardian acted to protect mentally incompetent person from actions of wife and another court-appointed guardian).

[75]*Accord, J.L. v. Parham*, 412 F.Supp. 112 (M.D. Ga. 1976), *prob. juris. noted*, 431 U.S. 936 (1977); *Kidd v. Schmidt*, 399 F.Supp. 301 (E.D. Wis. 1975); *Saville v. Treadway*, 404 F.Supp. 430 (M.D. Tenn. 1974); *In re Long*, 25 N.Ca.App. 702, 214 S.E.2d 626 (1975); *In re Roger S.*, 141 Cal.Rptr. 298, 569 P.2d 1268 (S.Ct.Cal. 1977). These issues have been discussed in the literature. Wilson, *The Rights of Adolescents in the Mental Health System* (1978); Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Calif. L. Rev. 840 (1974); Teitelbaum & Ellis, *op. cit. supra* note 51.

Mere approval by psychiatrists cannot support a mental health commitment to an institution. *See* discussion and cases cited at 36-39 *supra*. Certainly, the state of the art of psychiatry is not such that the confinement of tens of thousands of persons should be left to the judgment of these practitioners.[76] This field is beset with "uncertainty of diagnosis" and "tentativeness of professional judgment." *Greenwood v. United States*, 350 U.S. 366 (1956); *O'Connor v. Donaldson*, 422 U.S. 563, 579 (1975) (Burger, C.J., concurring).[77]

Mental illness is defined by the user of the term and that definition depends upon the norms employed by the definer:

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[76]This case does not involve second-guessing a "medical diagnosis" or interference with the provision of standard medical care to juveniles. First, with regard to the retarded, retardation is not a medical problem and is not treated medically. *See* 979a-982a; *Halderman v. Pennhurst State School and Hospital, supra* note 31 (differences between mental illness and mental retardation, and their treatments, described). Second, with regard to both mental retardation and mental illness, it is only when medical and other recommendations result in a deprivation of liberty, non-medical risks and imposition of stigma that, as in the case at bar, the protections of due process are triggered. *See* note 71 *supra*. For a detailed review of the literature, *see* Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. Calif. L. Rev. 527 (1978).

[77]One important study showed that diagnoses by psychiatric residents were highly influenced by the imagined socio-economic status of the patient and by the perceived diagnosis of other psychiatrists *independent* of the clinical picture presented. Lee & Temerlin, *Social Class, Diagnosis and Prognosis for Psychotherapy*, in *Psychotherapy: Theory, Research and Practice* 181 (1970); Ennis & Litwack, *Psychiatry and the Presumption of*

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> And, because of the unavoidably ambiguous generalities in which the American Psychiatric

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Expertise: Flipping Coins in the Courtroom, 62 Calif. L. Rev. 693 (1974) (full review of the literature and legal implications); Beck, *Reliability of Psychiatric Diagnoses: A Critique of Systematic Studies*, 119 Amer. J. of Psychiatry 210 (1962); Chesler, *Women and Madness* (1972) (Chapter 2, "Asylums"); Edelman, *Inter-Therapist Diagnostic Reliability*, 25 J. of Clinical Psychology 394 (1969); Goldberg & Werts, *The Reliability of Clinicians' Judgments: A Multi-Trait—Multi-Method Approach*, 30 J. of Consulting Psychology 199 (1966); Katz, Cole & Lowery, *Studies of the Diagnostic Process: The Influence of Symptom Perception, Past Experience and Ethnic Background in Diagnostic Decisions*, 125 Amer. J. of Psychiatry 937 (1966) (44 experienced psychiatrists viewed a filmed interview with a patient. 17 saw the person as psychotic, 26 saw the patient as non-psychotic. When British and American psychiatrists were compared, the British saw less pathology); Pasamanik, Divity & Lefton, *Psychiatric Orientation and Its Relation to Diagnosis and Treatment in a Mental Hospital*, 116 Amer. J. of Psychiatry 127 (1959); Rosensweig, et al., *A Study of the Reliability of the Mental Status Examination*, 117 Amer. J. of Psychiatry 1102 (1961).

"Just as serious obstacles to the diagnostic and therapeutic process arise within the patient, they also arise within the therapist." Nicholi, *The Therapist-Patient Relationship*, in Nicholi, *The Harvard Guide to Modern Psychiatry* 3, 12 (1978). These obstacles, which can become "destructive" to the sensitive relationship between the therapist and the patient or prospective patient, include anxiety within the therapist (which may cause "blind spots" in hearing or understanding the patient's story), professional insecurity, fatigue, impatience "involving excessive eagerness to make the diagnosis," inattentiveness, restlessness, daydreaming, inappropriately intense feelings toward the patient. *Id.* at 12-16.

> Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there.

Livermore, Malmquist & Meehl, *On the Justifications for Civil Confinement*, 117 U. Pa. L. Rev. 75, 80 (1968).[78]

The defendants' extraordinary claim that mental commitments involve no determinative factual questions or disputes flies in the face of every mental commitment decision of this or any other court, the

[78] *See*, Roth, Dayley & Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 Santa Clara Law. 400, 403 (1973). More than a hundred years ago a court noted that commitment of children to reform school was based on differing perceptions of "poor parental care:"

> . . . there is not a child in the land who could not be proved, by two or more witnesses, to be in this sad condition.

People ex rel. O'Connell v. Turner, 55 Ill. 280 (1870). The situation is the same today regarding young persons who can be proved to be in the "sad condition" of mental disturbance. *See* Duehn, *The Effect of Practice Orientations on Clinical Assessment*, 46 Amer. J. of Orthopsychiatry 629 (1976) (extent of negative mental health labeling is determined, in part, by factors extraneous to patients' behavior); Rosenhan, *The Contextual Nature of Psychiatric Diagnosis*, 84 J. Abn. Psychology 462 (1975):

> Despite the DSM-II's attempts to elaborate symptomology associated with each disorder, behaviors are too variable and their meanings too dependent on contextual perception for them to be captured under the rubrics proposed by the DSM-II. The very ambiguity of behavior, the fact that its meanings are not automatically transparent, defeats such attempts at classification from the onset, at least within the psychiatric hospital.

histories of the named plaintiffs,[79] the record in the case,[80] and the voluminous medical literature.[81] The very existence of "mental illness" and the need for institutional care are, as the lower court found, facts which are subject to dispute and not amenable to purely medical determination. *See Specht v. Patterson*, 386 U.S. 605 (1967); *Baxstrom v. Herold*, 383 U.S. 107 (1966). *See also, Danforth, supra*, 428 U.S. at 104 (Stevens, J., concurring in part and dissenting in part) ("Similarly, even doctors are not omniscient. . . . In each individual case factors much more profound than a mere medical judgment may weigh heavily in the scales.").

Institutional psychiatrists are faced with conflicts of interest—with their facilities,[82] with their parents and their patients' families[83]—and have great difficulty

[79]What brought each named plaintiff to the institution and what suggested to the parent and professional a need for institutional treatment was not internal disturbances in thought or feeling but external behaviors and expressions which might or might not have actually occurred and which might or might not have a "normal" explanation. *See* notes 77 and 78 *supra*; LeBow, *Evaluating the Seriousness of Adolescent Adjustment Reactions*, 2 Primary *Care* 281 (1975). *See* Morse, *op. cit. supra* note 76.

[80]*See* notes 53-60 *supra*.

[81]*See* notes 75-78 *supra*.

[82]*See* testimony of Dr. Messinger at 629a-630a (pressures on psychiatrists to confirm colleagues' opinions and meet institutional needs) and Dr. Ingall at 599a (overcrowded clinics may overrecommend institutionalization).

[83]*See* Scheff, *Being Mentally Ill: A Sociological Theory* 148-149 (1966) (commitment is generally automatic where family requests it). Scheff also discusses a case in which a psychiatrist recommended a commitment for a young person who was *not*

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telling the sane from the insane, tending toward an overdiagnosis of mental illness.[84] Psychiatry, asked to adjudicate interpersonal and societal conflicts, is often called upon to be the agent of the state's police powers in ways that carry it beyond its recognized expertise.[85]

What is said above for psychiatry and mental illness is mirrored for mental retardation. The uncontradicted testimony and unchallenged factual findings reflect that "there are many mistakes" in identifying the retarded (981a) through confusion with physical characteristics or handicaps, testing problems, incorrect develop-

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thought mentally ill but who was having difficulties with his parents. *Id.* at 147. Where parents seek commitment of their child, the medical authority is forced into a conflict situation:

> While the goal of the psychiatrist will be expressed—and perceived—as the best welfare of the child-patient, it is the parent who has come to seek help, whose situation seems the most desperate, who seems the most reliable source of information about what is wrong, who is the closest to the psychiatrist in age and social outlook, and who is paying the psychiatrist's fee.

Ellis, *Volunteering Children, supra* note 75, 62 Calif. L. Rev. at 868 (note omitted). This view is confirmed by the expert testimony for all parties. *See* testimony of Dr. Feiner at 472a, 478a-479a; Dr. Sugar at 381a; Dr. Masterson at 732a-733a; Dr. Kandler at 542a; Dr. Ingall at 593a-594a; Dr. Messinger at 637a-638a.

[84]*See* Rosenhan, *On Being Sane in Insane Places*, 13 Santa Clara Law. 379 (1973), discussed in original opinion at 804a, n. 20. Indicative of this approach is the testimony for the defendants by Dr. Masterson who asserted that psychiatrists should first assume that the person before them is mentally ill (739a). *See* testimony at 737a-738a.

[85]*See*, Bazelon, *Forward, Symposium: Mental Illness, the Law and Civil Liberties*, 13 Santa Clara Law. 367 (1973); Szasz, *Civil Liberties and the Mentally Ill*, 9 Clev-Mar. L. Rev. 399, 407 (1960).

mental speculations, and the like (979a-983a, 1068a).[86] "[I]n many cases, people grow out of being retarded." (983a). Therefore, a history of mental retardation is not an infallible indicator or present retardation (982a).

Parents of retarded children receive consultation from professionals they consult, typically physicians other than psychiatrists. The physicians' advice is critical in the decision to institutionalize the child and, tragically, that advice is typically uninformed, without

[86]Mental retardation, by definition, consists of subaverage intellectual performance combined with behavioral maladaptation (979a). Grossman, ed., *Manual on Terminology and Classification in Mental Retardation* (1973). An assessment of behavior is thus a *sine qua non* of a finding of retardation. *Id.* On the intellectual aspect of the definition, serious questions have been raised regarding the accuracy of the tests used. *See, e.g.*, Mercer, *Labeling the Mentally Retarded* (1973). Erroneous diagnoses of mental retardation are not unusual. *See* Menolascino, *Emotional Disturbance and Mental Retardation*, 70 Amer. J. of Mental Deficiency 248 (1965). A web of circumstance, not intellectual functioning level, determines who is committed and who is not:

> Q. Well, isn't there, as I think many people believe, some relationship between a person's IQ or level of retardation and whether or not they are found in an institution?
>
> A. No, not at all. The people you find in institutions now, the reasons range from the parents don't want to let them come out or inappropriate reasons that they have been put in there. * * * It is circumstantial as to whether or not they have ended up in institutions.

Testimony of Commissioner Glenn at 980a-981a. Factual disputes arise in grounds asserted as the basis for commitment of the retarded (998a).

reasonable basis, and inappropriately and excessively oriented toward institutionalization.[87]

In some ways more than in the mental health area, mental retardation professionals who work in institutions are subject to pressures and conflicts of interest which make it impossible for them to independently evaluate people's need for commitment.[88] This occurs

[87]Literature collected in Teitelbaum & Ellis, *op. cit. supra* note 51. *See* Turnbull & Turnbull, eds., *Parents Speak Out: Views from the Other Side of the Two-Way Mirror* (1978) (accounts by retarded children's parents who are mental retardation professionals themselves); Kelly & Menolascino, *Physicians' Awareness and Attitudes Toward the Retarded*, 13 Mental Retardation 10 (1975); Testimony of Commissioner Glenn at 1004a, 1009a.

[88]Several pressures and conflicts are described in Commissioner Glenn's testimony at 1007a-1008a:

> First, there is a basic conflict of interest for somebody in the institution to make a decision about whether or not a person ought to go to that institution. That would be sort of like a store owner deciding whether or not a customer ought to come into his store or somebody else's store. Institutions, as I indicated earlier, are sort of fighting to prove their necessity and justify their existence. All the research in the past 35 years has shown that institutions are not appropriate for the developmental growth of mentally retarded persons, but there are a lot of people that continue to try to justify their existence and the only way they can do that is by having a population. With the move Federally and by states and professions that recognize the inadequacy of this historic institutionalization having a dramatic move toward deinstitutionalization, there is a real conflict where institutions have to have people to prove they should still be around.
>
> Another reason is the institutions, in the vast majority of cases, if not all the cases, would be ignorant of the other alternatives to someone being placed in their institution. Their responsibilities, obviously, would be the operation of that particular program.
>
> Also, the staffs of institutions by the very fact that they work there, think that they are doing the right thing, think

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"regardless of the goodwill or good faith of the institutional staff." (1008a). Psychologists, social workers, educators, and various social agencies often recommend institutionalization even though they may be aware that other alternatives would be more appropriate (1009a-1010a). Overcrowded clinics "very often" overrecommend institutionalization of the retarded (1010a).

E. The Requisites of Due Process.

The requirements of due process are flexible and depend upon an evaluation of the effect of government action on the private interest involved and of the risks and value of alternative procedures, as well as consideration of the government's interest. *Cafeteria Workers Union v. McElroy*, 367 U.S. 886, 895 (1961);

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> that they are the best place for people, and so everybody gets ego involved in what they are doing and have been doing for years and think only they can do the right job.
>
> Thus, an institution staff making a decision would naturally have a tendency toward saying people belong right there in their institutions.
>
> There is also the issue of institutional staff having a mentality of over-protectiveness, really feeling a person has to be brought into the institution and serviced by their staff and protected in that type of environment or the staffs wouldn't necessarily work there.

See testimony at 1008a ("superintendents start sneaking people in, to make sure they can get the same amount of money next year, same census on the rolls. . . .").

Mathews v. Eldridge, 424 U.S. 319, 335 (1976).[89] Notice, counsel and an opportunity to be heard are fundamental requirements where a deprivation of personal liberty—for whatever reason—is involved. *E.g., Specht v. Patterson*, 386 U.S. 605 (1967); *Baxstrom v. Herold*, 383 U.S. 107 (1966); *In re Gault*, 387 U.S. 1 (1967).

The limits of the process found due by the lower court deserve renewed emphasis at this point.[90] With the exception of notice of prolonged commitment and counsel or other trained representative, all rights may be waived, including presence at any hearings. It is expected that hearings will not be required in every case; a large number of hearings will be waived.[91] The forum for hearings which are held would be an "impartial tribunal" where the perspective and con-

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[89] *Mathews v. Eldridge* requires consideration of three concerns:

1. The private interest that will be affected by the official action. The right to be free from confinement in an institution and the consequences of such confinement—whether erroneous or not—have already been discussed.
2. The risk of erroneous deprivation through the procedures used and the probable value of substitute procedures. The inherently substantial risk of error in reliance on parental or professional decision-making is discussed above. The value of substitute procedures is discussed in this section of the brief.
3. The government's interest, including fiscal and administrative burdens, is discussed in this section of the brief.

[90] *See* discussion *supra* at 19-21.

[91] *Id. See* 811a, n. 26.

cerns of the parents or guardians could be fully aired.[92]

Many states provide hearings for young persons facing commitment.[93] Seven states make no distinctions among age groups in their commitment laws: Alabama, Alaska, Connecticut, Minnesota, Nebraska, New Hampshire and Virginia. Florida makes no

[92]The process is consistent with that urged by Professor John P. Wilson, Associate Dean, Boston University School of Law, in his new volume, *The Rights of Adolescents in the Mental Health System* 222-223 (1978):

> In view of this situation, due process seems to demand procedures which can be invoked by interested parties but which for the most part are not automatically applied in every admission. Where no one, including the child, objects to the arrangements being made, there seems no reason to disrupt the parent-child relationship beyond a review of the good faith and informed consent of all competent parties involved and periodic review of the need for hospitalization and treatment. On the other hand, in view of the possible abuses of the voluntary admission process and the growing independence and maturity of a juvenile child, procedures should be available to the need for admission whenever that child or another interested party raises an objection.
>
> One method of accomplishing this delicate task would be to inject an independent third party into the situation—an advisor and advocate for the child whose presence and assistance could not be waived by the parents. This person would counsel the child, and if the child then objected to admission or was incompetent to consent to admission, would represent him or her in a hearing, probably before a multidisciplinary review board. Ultimate appeal to a court would be possible. The review board would be responsible for either authorizing or denying admission once an objection was raised. Thus in contested cases this board would effectively perform the decision-making function now performed, in most states, solely by parents and an admitting physician.

[93]Wilson, *op. cit. supra* note 75, Appendix B, 301-308. The state-by-state information in the text is summarized from this appendix.

mention of parental authority to commit persons under 12. In three states, Rhode Island, Tennessee and Texas, the minor must consent to the commitment. In Iowa, South Dakota and Montana, an objecting minor receives a hearing, as do objecting minors 13 and older in Michigan. In Illinois and Montana, court approval is required for extended commitment, whether the minor objects or not (as noted previously, an objecting Montana minor receives a hearing). In the 35 other states, statutes require parents or guardians to consent to institutionalization.[94]

The record in this case and the findings of the lower court support a number of important practical observations concerning the need for and functions of commitment hearings for young persons.

Opportunity for a hearing for juveniles is proper and necessary in non-emergency situations.[95] Because of their immaturity and lack of experience, it is even more important that juveniles receive the protection of a hearing than adults.[96] Assistance of counsel is essential and can help treatment of juveniles; in no significant way could it hinder such treatment.[97] As the lower

[94]Two of those states, California and Wisconsin, have had their statutes invalidated, in whole or in part, by recent litigation. *See* note 75 *supra*.

[95]*See* testimony of Dr. Kandler at 542a-545a, 566a, 571a-572a, 573a-574a; Dr. Ingall at 596a-597a, 606a; Dr. Messinger at 622a-623a, 625a, 630a-631a; Dr. Feiner at 479a-480a; Commissioner Glenn at 1011a.

[96]*See* testimony of Dr. Kandler at 562a; Dr. Ingall at 589a-590a; Dr. Messinger at 630a-631a.

[97]*See* testimony of Dr. Kandler at 542a-543a; Dr. Ingall at 597a; Dr. Messinger at 633a.

court found, a hearing would not be unduly traumatic for juveniles and would not interfere with treatment or the parent-child relation; to the contrary, a hearing would encourage more appropriate resolution of problems and would have positive and beneficial effects on the child and his or her parents.[98] *See In re Gault, supra*, 387 U.S. at 26.[99]

Establishment of a due process impartial forum for a decision to institutionalize lifts the heavy responsibility from the parents[100] and reduces the possibility that the therapist will be seen by the juvenile as an adverse party.[101] A hearing does not interfere with therapy and has the further effect of encouraging a juvenile's cooperation with a treatment plan.[102] The opportunity for hearings would not discourage people from seeking treatment for juveniles (although it would, no doubt, deter unwarranted applications) but would result in agencies and professionals performing more effectively, the avoidance of the necessity for hearings, reduced use of institutionalization, and the

[98]Opinion at 1081a-1082a. *See* testimony of Dr. Kandler at 543a-545a, 565a-566a, 574a; Dr. Ingall at 591a, 596a-597a, 611a-613a; Commissioner Glenn at 1012a, 1013a-1015a, 1024a-1025a.

[99]Dr. Feiner testified that ". . . it has been said that some children would rather be fair than be loved. So, there is a sense that a judicial hearing responds to in children" (483a). *See* testimony of Dr. Messinger at 624a.

[100]Testimony of Dr. Feiner at 481a, 495a; Commissioner Glenn at 1013a-1014a.

[101]Testimony of Dr. Messinger at 624a-625a; Dr. Ingall at 612a-613a.

[102]Testimony of Dr. Kandler at 561a, 574a; Dr. Ingall at 597a; Dr. Messinger at 633a.

provision of more appropriate care in particular cases.[103]

Notice. Turning to the specific procedural protections recognized by the lower court, the first is notice of a commitment which is to last longer than three days. Without advance notice, the fundamental "right to be heard has little significance."[104] In mental commitment cases, notice is at least as essential, if not more so, than in proceedings which do not result in deprivation of liberty. *Cf., Goldberg v. Kelly*, 397 U.S. 254 (1970). Where a proceeding will be held which will determine whether a person is indeterminately and involuntarily institutionalized, advance notice is imperative.

The speculative fear of an unspecified trauma flowing from notice cannot justify abandonment of this first step in providing a process which is due under the circumstances. *In re Gault, supra*. In its comprehensive study, the American Bar Foundation noted:

> The humanitarian desire to eliminate or curtail the use of notice in such cases raises certain questions, however. It may be, for example, that the experience of receiving notice would prove no more traumatic for the patient than the experience of suddenly finding himself detained in a mental institution.[105]

[103]*See* testimony of Dr. Kandler at 574a; Dr. Messinger at 638a-640a; Dr. Feiner at 494a-495a; Commissioner Glenn at 1014a-1015a.

[104]Opinion at 802a, citing, *inter alia, Grannis v. Ordean*, 234 U.S. 385, 394 (1914); *In re Gault*, 387 U.S. 1 (1967); *Mullane v. Central Hanover Trust Co.*, 339 U.S. 306 (1950).

[105]American Bar Foundation (Brakel & Rock, eds.), *The Mentally Disabled and the Law* 51 (1971). "Since effective notice is a prerequisite to the exercise of an individual's other due

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Counsel. In criminal proceedings, *Argersinger v. Hamlin*, 407 U.S. 25 (1972), and in juvenile proceedings, *In re Gault, supra*, the guiding hand of counsel is a right which assures that no person is deprived of liberty without the aid of an expert able to "cope with problems of law, to make skilled inquiry into the facts, to insist upon regularity of the proceedings and to ascertain whether he has a defense and to prepare and submit it." *In re Gault, supra*, 387 U.S. at 36.

The lower court recognized that it "may not always be necessary to appoint a lawyer so long as a substitute

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process rights, mandatory notice should itself be a requirement of due process" in mental health cases. Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1274-1275 (1974) (notes omitted). Eighty years ago, in a landmark and often-cited case, the Kansas Court of Appeals explained the logic of requiring notice in mental commitment proceedings:

> Notice and opportunity to be heard lie at the foundation of all judicial procedures. They are fundamental principles of justice which cannot be ignored . . . it will not do to say that it is useless to serve notice on an insane person; that it would avail nothing because of his inability to take advantage of it. His sanity is the very thing to be tried.

In re Wellman, 3 Kan. App. 100, 103, 45 P. 726, 727 (1896).

Consider how differently the commitment of Edward B. would have been had he been given notice under the court's order. Rather than arriving at the institution and being informed that he would be there indefinitely, after being "tricked" by his parents into coming and after being made to feel "like a prisoner," he would have been told that, if he had to stay longer than a few days, he would have a lawyer or other representative to help him out and that he could have a chance to tell his side of the story to a neutral party. The positive effect on Edward B.—and the plaintiff class as a whole—is readily apparent.

procedure adequately protects the child's interest," for example, a guardian who might, if necessary, "have the power to retain a lawyer." (1079a, n. 47). This flexibility permits informality and allows a minimum of legal technicality while assuring that, where legal expertise is essential, it is provided.

Mandatory appointment of counsel or other trained representative in juvenile commitments assures that a child has the full support necessary to avoid pressures of family and institutions and provides assistance in making the critical decision whether to waive an evidentiary hearing. *See Gallegos v. Colorado*, 370 U.S. 49, 54 (1962); *Haley v. Ohio*, 332 U.S. 596, 599-601 (1948); Harris, *Mental Illness, Due Process and Lawyers*, 55 A.B.A.J. 65 (1969) (noting danger that young persons will be induced to commit themselves to mental institutions unless their rights are explained to them by lawyers). With parents, doctors and institutional staff all urging commitment, and with no independent confidant and advisor, it is impossible to expect a child to make an "intentional relinquishment or abandonment" of a fully known right. *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938). Where the young person is unable to comprehend exactly what is happening, appointment of a conflict-free advocate is even more essential. *See, e.g.*, testimony of Commissioner Glenn at 1019a-1020a.

Hearing. Balancing the young person's liberty interest in a pre-commitment hearing against the interests of the state and parents or guardians, the lower court held that a hearing is not constitutionally required prior to institutionalization (800a-801a).

However, both a probable cause hearing and a full hearing are required (unless waived) within a reasonable period of time in order to support an indefinite mental commitment. *In re Barnard*, 455 F.2d 1370 (D.C.Cir. 1971); *Lessard v. Schmidt, supra* note 34. In order to determine if "the nature and duration of confinement bear some reasonable relation to the purpose for which the individual is committed," *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), a hearing opportunity is indispensable. *See McNeil v. Director, Patuxent Institution*, 407 U.S. 245 (1972).

Impartial Tribunal. Without specifying any requirement for a judicial hearing, and with the implication that an administrative hearing would be sufficient, Opinion at 1082a, n. 53, the lower court states "only that the tribunal must be neutral and unbiased." *Id.* at 1082a. In criminal, quasi-criminal and administrative processes, the right to an "impartial decision-maker" is an "essential" right. *Goldberg v. Kelly*, 397 U.S. 254, 271 (1970); *Gibson v. Berryhill*, 411 U.S. 564 (1973), and *cf., Arnett v. Kennedy*, 416 U.S. 134, 170, n. 5 (1974) (Powell, J.) with *id.* at 196-199 (White, J.) and 216 (Marshall, J.). The probable cause for detaining a person in an institution cannot be determined by the very people who apply for and seek the institutionalization. *Gerstein v. Pugh*, 420 U.S. 103 (1975).

Presence of Person. While the right to be present is not absolute, *Illinois v. Allen*, 397 U.S. 337 (1969), there can be no doubt that persons subject to civil commitment have a right to be present. *Specht v. Patterson*, 386 U.S. 605 (1972). To avoid any trauma to particular individuals, the lower court specifically held

that the child's representative "has the option of waiving the child's presence at the hearing if there is a potential for trauma," 1082a, subject to the tribunal's approval. The right to be present has value to others beside the subject of the proceedings. The individual's appearance provides the factfinder with an opportunity to observe his or her demeanor and to compare observations with those of psychiatrists, other doctors and professionals, parents and other witnesses. *See* Note, *Developments in the Law, supra* note 105, 87 Harv. L. Rev. at 1282-1283. The chance to tell one's side of the story is an essential one.

Rights at the Hearing. The District Court held that "because of the tremendous personal as well as societal loss error might cause," a young person facing involuntary indeterminate mental institutionalization is entitled to "the rights to confront and to cross-examine witnesses against him, to offer evidence in his own behalf and to offer testimony of witnesses. . . ." (810a). These traditional factfinding tools are essential in the commitment process so that conflicts may be resolved and the true state of affairs ascertained. *Specht v. Patterson, supra*, 386 U.S. at 610; *Lynch v. Baxley*, 386 F.Supp. 378, 394 (M.D.Ala. 1974), citing, *Washington v. Texas*, 388 U.S. 14, 19 (1967).

Standard of Proof. The danger of erroneous commitment must be weighed against the dangers of not committing those who may be said to require institutionalization; this is the analysis required to determine the appropriate standard of proof. While in juvenile proceedings, this Court has required a reasonable doubt standard, *In re Winship*, 397 U.S.

358 (1969), lower courts are divided on the standard to be used in the similar mental health context. *See, e.g., In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973) (reasonable doubt); *Lessard v. Schmidt, supra* at note 34 (reasonable doubt); *Suzuki v. Quisenberry, supra* at note 37 (reasonable doubt); *Lynch v. Baxley, supra* at note 37 (clear, unequivocal and convincing); *Dixon v. Attorney General of the Commonwealth of Pennsylvania, supra* at note 37 (clear, unequivocal, convincing). The lower court here adopted the clear and convincing standard, choosing not to follow *Winship* because the undeveloped state of psychiatry "creates too great a risk of erroneously releasing children in need of institutionalization." (809a). This issue is presently before the Court in *Addington v. Texas*, No. 77-5992.

The second part of the *Mathews v. Eldridge* test requires inquiry into whether the above procedures would actually reduce the likelihood of error.[106] Expert

[106]Defendants ingenuously opine that these due process protections will not erase the public's stigmatizing reaction to mental disability and that, in many cases, the tribunal will confirm the recommended institutional care. Due process is not intended to alter public opinion, but to protect children not in need of commitment from the disapprobation which, at this point in history, is the inevitable result of mental commitment. In cases where hearings are not waived, the task is to arrive at a just result, not to tally up an impressive scorecard of "wins" or "losses." Nevertheless, recent studies of commitments demonstrate the ability of courts to make independent judgments. Hiday, *Reformed Commitment Procedures: An Empirical Study in the Courtroom*, 11 Law & Soc'y Rev. 651 (1970); Zander, *Civil Commitment in Wisconsin: The Impact of Lessard*, 1976 Wis. L. Rev. 503, 552. Older studies, such as the one relied on by the

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testimony at trial and the lower court's findings support a positive answer to this question. The traditional purposes of a due process hearing would be served: facts would be sifted, all evidence weighed, and reasons for and against commitment carefully and impartially examined.

A further crucial function of the hearing will reduce another sort of error. There are many young persons who will be found to need care and residential services outside the family home. "The real question in these cases is whether care *in an institution* is required or whether there is some less restrictive alternative which would better meet the individual's needs." Teitelbaum & Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application*, 12 Family Law Quarterly 153 (Fall, 1978).[107]

(footnote continued from preceding page)

defendants, indicated frequent unquestioning reliance on medical recommendations, especially where procedural protections were lax. *E.g.*, Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. Health & Human Behavior 66 (1968) (noting, however, an extremely high statistical association between respresentation by counsel and decision not to commit).

[107]The lower court held that "Where the state sanctions the restriction of a child's liberty rights, such restriction should intrude upon those rights to the smallest possible degree necessary achievement of the purposes of the restriction." (1081a) (citations omitted). This "least restrictive alternative right" is recognized in, *e.g., O'Connor v. Donaldson, supra*, 422 U.S., at 575, citing *Shelton v. Tucker*, 364 U.S. 479 (1960); *Welsch v. Likins*, 373 F.Supp. 487 (D.Minn. 1974); *Halderman v. Pennhurst State School and Hospital, supra; Dixon v. Weinberger*, 405 F.Supp. 974 (D.D.C. 1975); *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969); *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966).

Explanation of appropriate alternatives for care can meet the needs of both the young person and his or her parents:

> The existence of these alternatives [community-based, non-institutional facilities] means that the placement choice is not a "zero-sum game" in which either the parents or child must "lose." Rather, independent review of the child's needs, the family's needs, and the options available to them may enhance the lives of each.

Id. at ___.

The final application of the *Eldridge* test requires evaluation of the state's interest in avoiding the provision of additional procedures. At the hearing held on the state's stay request, the state was unable to provide any information at all on the number of hearings which might be required or on the costs of implementing the lower court's order. Memorandum of July 17, 1978. Assuming there will be some cost in protecting the constitutional rights of the plaintiffs, the state's interest in protecting its fisc is outweighed here by the private interests and the risk of error, as in similar delinquency and adult mental health contexts. Further, avoidance of institutional care and diversion of some cases to community-based programs will result in substantial cost savings to the state. *See Halderman v. Pennhurst State School and Hospital, supra; J.L. v. Parham, supra*, 412 F.Supp. at 126. Finally, it must be observed that the state has no interest in the erroneous or unnecessary confinement of any of its citizens, irrespective of age.

F. Neither the State's Statutes Nor Regulations Affect the Unconstitutionality of Commitment Without Hearing Before an Impartial Tribunal, Counsel or Other Trained Representative and Other Rights.

The 1966 Act and Regulations

The basic constitutional infirmity of Sections 402 and 403 of the 1966 Act is the failure to guarantee the minimal due process rights specified in the lower court's order and discussed above. Parents and guardians are permitted to institutionalize retarded young persons, simply upon application, with no protection for the child. Such a system cannot stand.[108]

The regulations issued in 1973[109] do nothing to cure the constitutional flaws noted above. Because the legal and operational problems with these provisions are discussed in great detail by the lower court (1083a-1085a) and by the only expert on the retarded to testify (1015a-1023a),[110] they are dealt with in a summary fashion below.

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[108]The constitutionality of the statute alone (without the regulations) is before this Court. George S., Gina S. and Nancy Louise D. were each committed before 1973 when the regulations were promulgated. The regulations did not require that already-commitment persons receive notice of any additional rights (Opinion at 1076a, n. 42).

[109]As the lower court noted (1059a, n. 11), the 1973 regulations apply only to commitment of young persons as retarded under the 1966 Act, and not to commitment of young persons as mentally ill under the 1976 Act (949a-950a).

[110]Commissioner Glenn qualified as an "expert in the area of mental retardation, care and rehabilitation of retardation institutions and community care for the retarded in the United States." (977a). Her paragraph-by-paragrph analysis of the regulations is uncontradicted.

Paragraph 1 of the regulations provides for referral of a retarded juvenile by an agency, pediatrician, general physician or psychologist. The institutional director or delegate, under paragraph 3, conducts an examination. As found by the District Court, the referral sources "may have no knowledge or training whatsoever concerning the problems of mental retardation, while the Director of the Institution, who has interests different from those of the child, may be placed in a position of conflict in making the decision to commit." (1084a, notes omitted). Referrals are often made as a "cop-out" to avoid the effort of alternative placements (1009a, 1084a, n. 57). This referral system is subject to serious abuse:

> One of the patterns of behavior for parents attempting to institutionalize their child has always been a shopping behavior, to shop around until they could get the right words on the right page from whatever physician they could find or psychologist; not just parents, other social agencies, social case workers, welfare workers.

Testimony of Commissioner Glenn at 1016a-1017a.

The referral body's evaluation, confirmed by the institution, is an improper legal basis for commitment. It is unconstitutional for persons to be confined solely on the basis of medical certifications. *See* cases cited *supra* at note 37. *See also, Wyatt v. Aderholt*, 358 F.Supp. 1382 (M.D. Ala. 1973) (sterilization of retarded "cannot be left to the unfettered discretion of any two officials or individuals"). The regulations here codify exactly what the law condemns.

The regulations require a skimpy evaluation, "certainly a limited documentation to make a life-long

decision for a person" (1017a), fail to require any specific reasons for institutionalization (Opinion at 1083a, n. 55), and omit entirely the professional prerequisites for a proper report (1017a-1018a).

For retarded persons under 13, no procedures in addition to the above exist. "There is no assurance whatsoever that the interests of the child will be weighed in making this decision. Therefore, this procedure does not provide the protections furnished by hearing before an 'unbiased tribunal'." (Opinion at 1084a-1085a).

Retarded persons over 13 receive a technical notice of rights about which, the expert testified, "Mentally retarded people would not be able to read the written notification or understand the explanation of his rights or have ever had the opportunity to learn how to use the telephone. . . ." (1019a, Opinion at 1085a).[111]

Those who understand the notice and want to object are "typically afraid to" protest because of the "atmosphere of pressure" in an institution." (1020a). "It's putting an awful lot of burden on young retarded persons to stand up against a big institution. . . ." (1021a).[112]

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[111] The regulations add insult to injury by providing that, if the juvenile is "incapable of understanding," the institutional staff member merely notes that fact on the form, without taking further protective action. (1059a) (Regulations, Par. 8).

[112]

> The fact that a new "patient" may act in a passive manner and not protest should not be taken "to be a meaningful acceptance of commitment."

Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 Tex. L. Rev. 424, 447 (1966). *See Haley v. Ohio*, 322 U.S. 596 (1948); *In re Gault*, 387 U.S. 1 (1966). One

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Finally, the regulations do not set a time limit within which a hearing must be held if the retarded child who happens to understand his or her rights is courageous enough to object. It may be one week, two weeks, a month or more for all the regulations neglect to say. Even a short commitment can be dangerous to the individual and, equally important, can cause serious hardship for the parents (1023a).

The 1976 Act

Unadorned by any regulations affecting commitment rights, the 1976 Act permits persons 13 and younger to be volunteered into mental institutions for indefinite periods without "a required post-commitment hearing" and in the "absence of counsel to advocate the interests of the child." (Opinion at 1086a).[113] The statute ignores the obvious fact that the needs of these very young people demand special protection (*see* testimony of Dr. Messinger, quoted at 1086a, n. 61).

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commentator explains the particular need for an advocate for young people facing commitment:

> Because young persons usually are more susceptible to persuasion than are older persons, there is a greater danger that they will be more easily induced to commit themselves voluntarily to mental hospitals unless their rights are carefully explained to them by lawyers.

Harris, *Mental Illness, Due Process and Lawyers*, 55 A.B.A.J. 65 (1969).

[113]The confirmation of the new commitment by an institutional "treatment team" and any accompanying psychiatric/psychological reports provides no added protection, as the lower court observed (1086a, n. 60).

When such institutionalized juveniles object to their confinement or express a desire to leave the institution, as the named plaintiffs have, the defendant institutional directors do not provide counsel or take action to assure either discharge or a hearing on the juveniles objections because the defendants believe they have the right not to take such protective measures (Stipulated at 950a).

Reliance on an unspecified "responsible party" to intrude, evidently by chance, unspecified days or months after commitment, to request a hearing is plainly unacceptable (Section 206(b) of 1976 Act, Opinion at 1086a-1087a). It would be harmful and counter-therapeutic to rely on the speculative possibility of a post-commitment hearing:

> I think it is a most inadequate provision and it is closing the barn door after the horse is out. I think it is disastrous to hospitalize a child and then find out, by golly, it wasn't necessary. That is playing with a child's life.

Testimony of Dr. Messinger at 631a (discussing the post-commitment hearing under the 1973 regulations). *See also* testimony of Dr. Feiner at 482a; Dr. Ingall at 596a.

The procedures for "voluntary" commitment of the subclasses of young persons committed as mentally ill and mentally retarded are unconstitutional on their face and as applied to the twelve named plaintiffs and those they represent.

II.

INDETERMINATE CONFINEMENT OF YOUNG PERSONS IN STATE-LICENSED INSTITUTIONS CONSTITUTES "STATE ACTION" WHERE THE STATE DELEGATES TO PRIVATE ENTITIES THE POWER TO DEPRIVE PEOPLE OF LIBERTY AND, ALTERNATIVELY, WHERE COMMITMENT TO INSTITUTIONS IN PENNSYLVANIA IS A POWER TRADITIONALLY EXCLUSIVELY RESERVED TO THE STATE.

All mental health and mental retardation institutions in Pennsylvania which are not state-owned and operated must be licensed and/or approved by the Department of Public Welfare (949a). Such facilities are required to utilize and act in conformity with the commitment procedures in both the 1966 Act and the 1976 Act. *Id.* As to these state-licensed institutions (and *not* as to state-owned institutions), the defendants suggest to this Court that "state action" for Fourteenth Amendment purposes is lacking.

"State action" is present for these commitments, plaintiffs submit, because (1) the state has delegated to parents, guardians and institutions a power not possessed by the state, the power to deprive persons of liberty without minimal due process procedural protections, and alternatively, (2) power over mental commitments is traditionally exclusively reserved to the state in Pennsylvania.

A. "State Action" Is Present Where the State Delegates to Private Entities a Power Not Possessed by the State, the Power to Deprive Persons of Liberty Without Minimal Due Process Procedural Protections.

Where a state law "puts its power behind,"[114] "places the power of the state behind,"[115] "fosters or encourages,"[116] is a "joint participant,"[117] or is "only one of several co-operative forces" leading to the constitutional violation,[118] otherwise private action is within the reach of the Fourteenth Amendment. It is insufficient if the state merely "authorized and approved" the challenged private action, *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 354 (1974), or if the state decides not to act in a "purely private dispute." *Flagg Brothers, Inc. v. Brooks*, 98 S.Ct. 1729 (1978).

Unlike *Jackson* and *Flagg Brothers*, here the state has affirmatively acted to require every parent or guardian committing a child, and every institution confining a child, to use certain procedures and to act in accordance with the challenged statutes. This is not a private commercial dispute and does not involve mere regulation of private business activities. Unlike *Jackson* and *Flagg Brothers*, a fundamental constitu-

[114] *Gray v. Sanders*, 372 U.S. 368 (1963).

[115] *Anderson v. Martin*, 375 U.S. 399, 402 (1964).

[116] *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 176-177 (1972).

[117] *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 357-358 (1974).

[118] *United States v. Guest*, 383 U.S. 745, 755-756 (1966). *See, Norwood v. Harrison*, 413 U.S. 455 (1973), cited with approval in *Jackson, supra* note 117.

tional right—the right to liberty in its core sense—is implicated and the state law explicitly supports and mandates the deprivation of that right without due process.

The *Danforth* and *Bellotti* parental consent to abortion cases rest upon an implicit state action finding where parents are acting under a state law which grants them authority in connection with medical procedures claimed for a child. In that situation, "the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto," *Danforth*, 428 U.S. at 74, over a child's right. It makes no difference whether the doctors, clinics or hospitals involved in the abortion (or mental commitment) are "private" or "public;" the determinative factor is the state laws's embodiment of parental power to veto a constitutionally protected interest of a young person. Where the state cannot deprive a person of liberty without minimal due process, it cannot delegate that right to a parent or guardian or mental institution.[118a]

B. "State Action" Is Present Where Mental Commitment Is a Power Traditionally Exclusively Reserved to the State in Pennsylvania.

As defendants are evidently unaware, commitment of the mentally disabled in Pennsylvania (since the first

[118a] The only mental health case cited on this issue by defendants has been vacated as moot. *In re John S.*, 135 Cal.Rptr. 893, 901, *vacated as moot*, 66 Cal.App.3d 343 (1977). In any event, that case involved no state action issue, as California "does not control either admissions or treatment policies" at the private institution, and as the court found no state involvement at all. *Id.*

commitment in 1676) has been a "power traditionally exclusively reserved to the State," *Flagg Brothers, Inc. v. Brooks*, 98 S.Ct. 1729 (1978). Parents and guardians never had the power to commit children to non-governmental institutions freely until the 1966 Act was passed. Since private licensed mental facilities were first established, they have all been required to utilize state commitment laws and there has been a "sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may fairly be treated as that of the State itself." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974). The use of mental commitments, under the law, has been as different from general medical care as black from white.

English Law as Brought to Pennsylvania. Settlement of Pennsylvania by the English brought with it the common law powers of chancery courts over idiots and lunatics. These powers were delegated by the Crown as *parens patriae*. 2 Story, *Commentaries on Equity Jurisprudence* 591 (1836). *See also, M'Elroy's Case*, 6 W. & S. 452 (C.P. Phila. 1843). English chancery procedures involved a petition, an inquisition "which is always had" and trial of the case by a jury. Story, *op. cit.* at 594-595.

Appropriately, the first record of a mental commitment in Pennsylvania involved a parent alleging a child's mental infirmity. In 1676, according to court records of Upland (Delaware) County, a father petitioned for relief from the care of his insane son. The court ordered a "block-house" to be built to confine the son and a tax levied to cover the costs. Deutsch, *The Mentally Ill in America* 42 (2d ed. 1949); 7 *Memoirs of the Historical Society of Pennsylvania* 102-103.

Pennsylvania courts were issuing lunacy and idiocy inquisitions as early as 1728. Pennsylvania (Colony) Court of Chancery, *The Registrar's Book of Governor Keith's Court of Chancery of the Province of Pennsylvania* at 40, Case No. 8 (1728) (creditors sought writ against debtor); *Id.* at 61, Case No. 27 (1734-1735) (father sought writ against son).

Pennsylvania Constitution. When the colony became a state, the sovereign chancery power over "the care of the persons and estates of those who are *non compotes mentis*" was delegated to the courts of common pleas by the Pennsylvania Constitution of 1776, Art. V, §24 (1776). This delegation of a clear exclusive power continued over the following century's three constitutions. Pa. Constitution, Art. V, §6 (1790); Pa. Constitution, Art. V, §6 (1838); Pa. Constitution, Art. V, §20 (1873). *See also, Clark's Case*, 22 Pa. 466 (1854).

Operation of Common Law Writ. As first codified by the legislature in 1836, the mental commitment process applied to both the mentally ill and retarded under its provisions for "lunatics." Act of 13 June 1836, §67, P.L. 605. Upon application to the court, a writ *de lunitaco inquirendo* issued. Notice to the alleged lunatic or to relatives or friends was required. Act of 13 June 1836, §4, P.L. 593. *Relatives or friends seeking a finding of lunacy were not competent to receive notice. Hinchman v. Richie*, 4 Clark 184, 7 Pa.L.J. 268, Brightly N.P. 143 (Phila. 1847). Notice was mandatory. *Comm. ex rel. Stewart v. Kirkbride*, 7 Phila. 8, 2 Brewst. 419 (C.P. 1868).

A commission was then appointed by the court to secure six twelve persons for the inquest into the person's state of mind. Act of 13 June 1836, §§3, 7, P.L. 592, 595. Lunacy was a jury question. *In re Weaver*, 116 Pa. 225, 9 A. 323 (1887). Commissions existed in substantially the same form until 1951.

After a hearing and finding by the commission, the court issued its orders respecting the custody and care of the person and his or her estate. Act of 13 June 1836, §13. Generally a person was confined to the custody of another private party. *Hinchman v. Richie, supra; In the Matter of Kenton*, 5 Binn. 613 (1813); Story, *op. cit.* at 592.

Nobody could be confined in any asylum except after a trial with witnesses and counsel for the alleged lunatic. *Commonwealth v. Spink*, 137 Pa. 255 (1890). One court declared the governing principles in this way:

> It is abhorrent alike to our sense of justice and to all judicial precedent that character, liberty, and estate should be swept away from him without a hearing or opportunity for defence. To hold otherwise would be contrary to every principle of reason and justice.

Comm. ex rel. Stewart v. Kirkbride, 7 Phila. 8, 11, 2 Brewst. 419, 425 (1868).[119] A person before a commission had the rights of a criminal defendant. *In re Lincoln*, 1 Brewst. 392 (C.P. 1867).

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[119] In emergencies, then as now, commitment was permitted on a tempoary basis without a hearing, with delayed compliance with the formalities of the law. *Comm. ex rel. Nyce v. Kirkbride*, 2 Brewst. 400 (C.P. Phila. 1868); *Hinchman v. Richie*, Brightly N.P. 180, 181 (C.P. Bucks Cty. 1847).

Judicial Supervision of Physicians' Certificates. In 1869, an alternative means of institutional commitment was added to what the sovereign state would permit. Two physicians were required to swear out a certification for the mentally ill or retarded person before a magistrate or judicial officer before any confinement could begin. Act of 20 April 1869, P.L. 78; 50 P.S. §42 (1923); 50 P.S. §1181 (1951).[120] Under the law, physicians' certificates could be traversed. *Comm. ex rel. Hembold v. Kirkbride*, 11 Phila. 427 (1876). *See infra*, text at note 121 for traverse procedures.

"Voluntary" Commitment of Adults and Children. No provisions for voluntary institutionalization existed until 1883. *The first such laws related to private institutions* and allowed only a seven day detention

[120]After 1923, one physician was required for the retarded. 50 P.S. §49 (1923); 50 P.S. §181(d) (1951). In 1925, commitment procedures for adults were changed so that retarded adults were committed under the same procedures as retarded children. *See*, 50 P.S. §51 (1923); 50 P.S. §50 (1925), and *see* discussion in text *infra*.

Two other statutory commitment requirements are of note. The legislature explicitly made the certificate procedure necessary for commitment to private institutions. Act of 9 May 1883, P.L. 25. Also, the indigent insane could be sent to institutions by petition of the directors of almshouses, county authorities, and jails. Act of 8 June 1881, P.L. 83; Act of 16 July 1897, §1, P.L. 301; Pa. Laws of 1863, P.L. 540. However, a commission resulting from such a petition would be set aside where it is not shown why the relations did not petition for a commission. *Madden's Lunacy*, 13 D.R. 658, 12 Luz. L. Reg. Rep. 38 (1903).

At least three persons had to be willing to swear to the alleged lunacy. *Metz's Case*, 5 Pa. Dist. Rep. 132 (C.P. Dauphin Cty. 1896).

agreement, executed in the presence of an adult friend and the institution's head. Act of 8 May 1883, P.L. 28-29. Voluntary admission to all hospitals was first provided in the 1923 Mental Health Act, under which, upon written notice, a person could not be detained for more than 10 days. 50 P.S. §41 (1923).

Significantly, a parent could not make an application on behalf of an allegedly mentally ill child without certification until 1966. 50 P.S. §4402, 4403 (1966). For confinement of a child more than 30 days, a court order was required as of 1961. Act of 20 September 1961, §304, P.L. 1527. Before that, the regular adult certification and court commitments were required.

Retarded children could be committed to the state institution for the feeble-minded upon parental application, but only after interrogatories were sworn under oath. Act of 3 June 1893, P.L. 291-292; Act of 15 May 1903, §§70, 13, P.L. 448. Ten years later, retarded adults and children became subject (as in 1836) to commitment as lunatics. Act of 25 July 1913, §10, P.L. 1322; Act of 12 June 1913, §13, P.L. 496; Act of 16 July 1919, §10, P.L. 987. In 1925, these procedures were altered so that only application and certification were used. Act of 27 April 1925, §2, P.L. 338.

Court Commitment. In 1869, the power to order confinement after a finding of lunacy by an inquisition was first incorporated into a statute. Act of 20 April 1869, P.L. 79-80 (hearing and notice required). Prior to 1869, the court did have the ability to confine where it was a question for the court whether restraint was proper. *Comm. ex rel. Nyce v. Kirkbride*, 2 Brewst. 400 (C.P. Phila. 1868); *Township of Franklin v. The Pennsylvania State Lunatic Hospital*, 30 Pa. 522 (1858)

(having been declared a lunatic by inquisition, a person unsafe to be at large could be subject to court proceedings). It was necessary to clarify this aspect of the law as, under the common law, a mere finding of "lunacy" did not mean automatic commitment to an institution. Court authorization was necessary for institutionalization of a lunatic. *Comm. ex rel. Draper v. Kirkbride*, 3 Brewst. 393 (C.P. Phila. 1869). Imbeciles could not be confined in a mental institution except pursuant to a court order or sworn certificate. *Comm. ex rel. Haskell v. Kirkbride*, 3 Brewst. 586 (C.P. Phila. 1869).

After a lunacy commission fulfilled its duties and reported to the court, the subject had the right to traverse the inquisition and proceed to trial on the issue. Act of 13 June 1836, §12, P.L. 594. The issue came to the court *de novo* and was to be tried by a jury. *Davidson v. Fry*, 11 Lanc. L. Rev. 357 (C.P. Lanc. 1892).[121]

A hybrid procedure was created in 1897 by statute. Act of 15 June 1897, §63, P.L. 162-163. Upon return of an inquisition, restraint of the person, or upon petition alleging restoration of sanity, the court had the duty to frame the issue and hold a jury trial under the common

[121]The issue to be tried on the traverse was whether a person's mind was so deranged as to disqualify him or her from conducting himself or herself with personal safety to self and others, and from managing and disposing of his or her own affairs and discharging his or her duties. *M'Elroy's Estate*, 6 W. & S. 451 (1843); *Commonwealth v. Meredith*, 14 Wkly Notes Cas. 188 (C.P. No. 2, 1884). Traverse was a common law proceeding originally for cases of idiocy *a nativate*. 2 Blackstone, *Commentaries on the Laws of England* 258; *McGinnis v. Comm. ex rel. McGinnis*, 74 Pa. 245 (1873).

law, if demanded. A verdict for the alleged lunatic was conclusive; a verdict against him or her was merely advisory. If no jury was demanded, the court would try the facts and issue a suitable order.

Summary and Conclusion. Beginning with the earliest colonial period of Pennsylvania history, through the Revolution and the state's first constitution, and continuing through the 19th Century and into the 20th Century, mental commitment has been a sovereign power strictly under the control and perogative of the state. Although procedures shifted and varied, any commitment to any institution, whether "public" or "private," was a matter of exclusive and paramount state concern and was, at all times and under all statutes, an action of the state. Mental commitment has never been simply a private matter.

Like education, elections, tax collection, fire and police protection, *Flagg Brothers, supra*, commitment of citizens to mental institutions in Pennsylvania has been a power "traditionally exclusively reserved to the state." *Jackson*, 419 U.S. at 352. Where parents or guardians, together with licensed institutions, deprive a person, of whatever age, of liberty, and label him or her mentally disabled, an action which is governmental in nature takes place.

In election cases, where political parties' activities are dictated by state law and where traditional state authority and functions are expressed through people who are not themselves government officials, state action is uniformly found. *See Nixon v. Condon*, 286 U.S. 73 (1932); *Gray v. Sanders*, 372 U.S. 368 (1963); *Anderson v. Martin*, 375 U.S. 399 (1964). *See also,*

Norwood v. Harrison, 413 U.S. 455 (1973) (intertwined educational function and unconstitutional practices). Here, the licensed institutions' commitment activities are dictated by state law and traditional state exclusive authority and functions are implicated when people are confined in such places. The result, a finding of state action, must be the same. There is "a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself." *Jackson*, 419 U.S. at 351.

III.

THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN CERTIFYING PLAINTIFF SUBCLASSES AND A DEFENDANT CLASS.

A. The Plaintiff Subclasses.

Pursuant to this Court's remand, the District Court exhaustively re-examined the plaintiff class issues (1065a-1076a) and certified two plaintiff subclasses, one of "all juveniles committed as mentally ill . . . who are under the age of fourteen" and the other of "all juveniles committed as mentally retarded . . . who are age eighteen or younger." (1089a). The defendants object in this Court on two grounds. "The first is the lack of representation for those of tender years in the class." Brief for Appellants at 55. The second is that "those who have been admitted for long term care cannot adequately represent the interests of those who have not." *Id.* at 56-57.

These objections were not raised below and should not be considered here for the first time. These objections have been belatedly inserted into the case for this appeal. They were not raised in the Answer to the Amended and Supplemental Complaint. *See* 917a (Par. 10) and 925a. They were not raised in Defendants' Response to Plaintiffs' Motion for Class Action (941a).[122] These objections were neither made nor briefed in the lower court before judgment was entered. Defendants should not be permitted to sit silent through litigation, and give no hint of any opposition to proposed plaintiff subclasses, and then to claim error for the first time on appeal. Absent any abuse of discretion by the lower court in deciding the issues, this Court should not consider these objections on appeal.

On their merits, the objections must be rejected. After careful and reflective analysis of factors affecting commitment rights of the mentally ill and the mentally retarded, the District Court turned to the "tender years" consideration and held that "the need for due process protection and the factors which this Court must consider in determining what process is due, are the same for older and younger retarded juveniles." (1071a). The "same factors hold true irrespective of the child's age." (1070a) (detailing the factual context).[123]

---

[122] Another unrelated objection, not raised on appeal, was presented (917a, 941a).

[123] Although the three retarded plaintiffs were over thirteen when suit was filed, all were committed before they reached thirteen and when they were not subject to the 1973 regulations. Nothing in the record indicates they ever received notice of any additional rights at any time after their thirteenth birthday (Opinion at 1075a, 1076a, n. 43). For these reasons, they may appropriately represent the under-thirteen retarded commitments. Also, as the lower court explained, "if the statutory scheme is unconstitutional with respect to the older juveniles who receive greater protections, then it is *a fortiori* unconstitutional with respect to the younger juveniles who receive far less protection." (1075a).

For those committed as mentally ill, the class was also found "cohesive and free from conflict," "irrespective of that child's age." (1073a). With absolutely nothing in the record to support this objection,[124] and absent any abuse of discretion, it must be rejected. Plaintiffs joined in class litigation "to assert a common right," *Hansberry v. Lee*, 311 U.S. 32, 44-45 (1940), and to challenge a state statute on constitutional grounds. In this circumstance, plaintiff subclasses including all ages of juveniles with common legal and factual connection with the statute are proper. *See Washington v. Lee*, 263 F.Supp. 327 (M.D. Ala. 1966), *aff'd*, 390 U.S. 333 (1968).[125]

[124]On the retarded, it is noted again that the defendants chose not to introduce any testimony at all; the only testimony on the retarded rebuts any age differences relevant to this case. On mental health commitments, defendants' only references to the record fail to support their claims. *See* Brief for Appellants at 56, n. 54.

[125]Mental commitment cases are regularly decided as class actions. *See, e.g., Rakes v. Coleman*, 318 F.Supp. 181 (E.D.Va. 1970); *Anderson v. Solomon*, 315 F.Supp. 1192 (D.Md. 1970); *Meisel v. Kremens*, 405 F.Supp. 1253 (E.D.Pa. 1975); *Goldy v. Beal*, 429 F.Supp. 640 (M.D. Pa. 1976). Where four plaintiffs sought to invalidate a sexual psychopath statute, a class was upheld with the three-judge court observing:

> Allowing a class action is further warranted because, where plaintiffs seek not to collect monetary damages but to strike down a constitutionally offensive statute, the requested relief (if granted) will necessarily affect all persons subject to the statute—whether formally combined as a class or not.

Davy v. Sullivan, 354 F.Supp. 1320, 1325 (M.D. Ala. 1973). *See* 4 *Newberg on Class Actions* §7942h, at 156 (1977). *See also Gesicki v. Oswald*, 336 F.Supp. 371, 374 (S.D.N.Y. 1971) (class attack by juveniles on "wayward minor" commitment law).

Defendants' second objection seeks to distinguish among young persons committed to an institution for "relatively long term care" and others who receive "no more than two or three weeks of in-patient care in a public or private facility." Brief for Appellants at 56.[126] Of course, all class members committed to institutions, even for a short time, are subject to deprivation of liberty, stigma and other risks (e.g., 1023a), all pursuant to the challenged statutes. The balancing suggested here by the defendants has already been accomplished by the lower court's allowance of a three day detention for emergency purposes and two week detention after a probable cause hearing. Class members need not be exact replicas of one another.[127]

B. The Defendant Class

In both the original proceedings and on remand, this litigation proceeded against a defendant class of institutional directors and discovery was had against all inpatient residential mental institutions in Pennsylvania. Defendants objected on remand to the defendant class, apparently on the grounds that a commonality of interests is lacking among the class members and that the defendant representatives are unable to adequately defend the interests of the class members. Brief for Appellants at 57 (Appellants never

[126]Defendants also refer to minors in community-based small family-like group homes. As explained previously, *supra* note 51, this case has nothing to do with such non-institutional facilities.

[127]Opinion at 1076a, n. 43. *See, Carpenter v. Davis*, 424 F.2d 257 (5th Cir. 1970); *Jones v. Milwaukee County*, 20 F.R.Serv.2d 1339 (E.D.Wis. 1975); *Sullivan v. Houston Independent School District*, 307 F.Supp. 1328, 1337-1338 (S.D. Tex. 1969).

briefed this issue in the lower court; their only reference to the issue is a statement of it at 941a).

The defendants presented no evidence at trial on any alleged "lack of common interests."[128] In fact, as discussed *supra* at n. 11, several licensed facilities were represented by counsel at the March 31, 1978 Final Hearing; they did not object to going forward at that time, they did not seek to present any evidence, and they did not object to the Attorney General representing their interests. They filed no motions with the lower court at any time, but did file amicus briefs after trial.

Notwithstanding the passivity of the defendants, the District Court carefully considered the question and, in its separate memorandum opinion (956a *et seq.*) and the final opinion (1071a, n. 37) rejected the challenge.

Where a state-wide class of diverse local entities caring for children is sued, and where each, as a practical matter and by operation of state law, would be bound by the result, a defendant class is appropriate. *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania*, 343 F.Supp. 279 (E.D. Pa. 1972) (Three-Judge Court) (retarded children sued all local school districts in Pennsylvania; as here, Attorney General properly represented the local interests throughout the litigation). *See also Samuel v. University of Pittsburgh*, 56 F.R.D. 435 (W.D. Pa. 1972) (defendant class of various institutions of higher learning across Pennsylvania).

[128] After entry of judgment, at the hearing on the stay, one state witness made some self-serving general references to licensed facilities in the context of implementation questions. The lower court never had occasion to consider the question with regard to the class issue and the defendants never asked the lower court to consider the question on the basis of any briefs or evidence.

Where inmates challenge a state statute and sue a defendant class of facility directors whose duty it is to implement the law, the class is upheld although the physical plants of the institutions across the state may vary and although, but for the challenged statute, the defendants may not be identically situated. *Washington v. Lee*, 263 F.Supp. 327 (M.D. Ala. 1966), *aff'd*, 390 U.S. 333 (1968) (defendant class of wardens, jailors, and sheriffs state-wide).

Just and complete litigation is possible, as here, without redundant parties who would simply add to the papers and pleadings and fill the courtroom with lawyers and witnesses without illuminating the issues at stake.[129]

The lower court's certification of the defendant class was correct and not an abuse of discretion.

[129] There are more than 400 state-licensed mental institutions in Pennsylvania (957a). For similar and analogous defendant class actions, *see, e.g., Rakes v. Coleman*, 318 F.Supp. 181 (E.D. Va. 1970) (defendant class of all state court judges empowered to order commitment); *Kendall v. True*, 391 F.Supp. 413 (E.D. Ky. 1975) (mental health commitments; defendant class of all Jefferson County judges); *Danforth v. Christian*, 351 F.Supp. 287 (W.D. Mo. 1972) (defendant class of persons enforcing vote residence requirements); *Congress of Ry. Unions v. Hodgson*, 326 F.Supp. 68 (D.D.C. 1971) (nationwide case; defendant class of railroads).

IV.

THE DISTRICT COURT DID NOT ERR IN REQUIRING THE DEFENDANTS TO ASSURE THAT YOUNG PERSONS PRESENTLY COMMITTED RECEIVE CONSTITUTIONAL STATE PROCEDURES TO DETERMINE WHETHER THEY ARE MENTALLY DISABLED AND IN NEED OF INSTITUTIONALIZATION.

The complaint herein requested injunctive and declaratory relief to assure constitutional state procedures in the commitment of young persons to mental institutions. Seeking only the guarantee of a state forum in which to have the claims against them determined, the plaintiffs sought from the federal court neither release nor any order with regard to their custody.

The District Court declared the plaintiffs' commitments invalid and ordered the defendants to initiate procedures to assure that all juveniles committed without hearings or counsel under the unconstitutional statutes receive the benefit of the minimal due process protections discussed above. Any hearings which might result would be in a forum created by the state.[130]

Appellants' assertion that *Preiser v. Rodriguez*, 411 U.S. 475 (1972), and *Wolff v. McDonnell*, 418 U.S. 539 (1973), bar such relief is based on a misreading of those cases and a failure to note other actions of this Court

[130]Defendants do not object to any of the declaratory relief granted. Their sole objection on this issue is to the prospective injunction at Par. 18C of the Order (1099a).

which support the District Court's order.

Preiser and *Wolff* held that litigants could not obtain from the federal courts, in actions under 42 U.S.C. §1983, relief affecting "the fact or duration of confinement" or effecting "immediate or a speedier release." *Preiser*, 411 U.S. at 500. *Wolff* noted that "an injunction restoring good time improperly taken is foreclosed" but specifically permitted federal courts to "fashion appropriate remedies for any constitutional violations ascertained, short of ordering the actual restoration of good time already cancelled." 418 U.S. at 555.

The District Court faithfully followed *Wolff's* proscription. It did not order "actual restoration" of liberty to plaintiffs and their class; it simply ordered that the defendant officials assure that proper state proceedings be afforded persons who have never had them. It would be in these state proceedings (not in the federal court) that commitment determinations would take place. The alternative to this orderly process would have been to allow the possibly erroneous commitment of thousands of persons to stand.

This Court's decision in *Gerstein v. Pugh*, 420 U.S. 103 (1975), directly supports the District Court and explains the error in appellants' argument:

> Respondents did not ask for release from state custody, even as an alternative remedy. They asked only that the state authorities be ordered to give them a probable cause determination. This was also the only relief that the District Court ordered for the named respondents. 332 F.Supp. at 1115-1116. Because release was neither asked nor ordered, the lawsuit did not come within the class of cases for which habeas corpus is the exclusive remedy. *Preiser v. Rodriguez*, 411 U.S.

475, 93 S.Ct. 1827, 36 L.Ed.2d 439 (1973); see *Wolff v. McDonnell*, 418 U.S. 539, 554, 94 S.Ct. 2963, 2973, 41 L.Ed.2d 935 (1934).

Id. at n. 6.[131] *See Gomez v. Miller*, 341 F.Supp. 323 (S.D.N.Y. 1972), *aff'd sub nom. Miller v. Gomez*, 412 U.S. 914 (1973) (class action challenging constitutionality of pretrial confinement in state mental institution for the criminally insane; relief sought and upheld was a state "determination of dangerousness as a prerequisite to retention"); *Goldy v. Beal, supra* note 125.

Appellants' reliance on *Kendall v. True*, 391 F.Supp. 413 (W.D. Ky. 1975), is misplaced. That case did not consider or discuss the *Preiser* issue. Also, the plaintiff mental patients in *Kendall* were incarcerated under a statute which provided for a maximum term of 60 days and under which a judicial hearing and counsel were provided. Here, the plaintiffs are under indeterminate commitments and have had no counsel or hearing.

Defendants further argue that, if it is held that those plaintiffs covered by paragraph 18C of the order must utilize habeas corpus, the exhaustion requirements of 28 U.S.C. §2254(b) would apply. However, §2254(b) applies only to "persons in custody pursuant to the judgment of a state court."[132] Plaintiffs were all

[131] In *Gerstein*, as in this case, persons were deprived of their liberty for substantial periods without probable cause hearings. The relief granted in *Gerstein*, as in this case, assured constitutional procedures in a state forum.

[132] If plaintiffs' §1983 claims went "directly" to the propriety of their confinement and also sought from the federal court either "immediate release" or a "shortening" of confinement, then under *Preiser* they would be fatally "close to the core of habeas corpus" even though they are not in custody under a state court

(continued)

committed without any involvement of a state court or other adjudicatory body whatsoever. There is no state corrective process available and effective to protect the plaintiffs' rights; no exhaustion of remedies is required because there are none to exhaust.[133]

Principles of federalism were similarly respected by the District Court. No state proceedings were interfered with; in fact, the state executive, judicial and legislative branches are left free to continue commitment of young persons, so long as the procedures used do not violate the Constitution.

CONCLUSION

For the above reasons, it is respectfully submitted that the Court should affirm once more that the Constitution is not for adults alone and that the massive curtailment of liberty inherent in mental institutionalization necessitates substantial procedural protections under the Due Process Clause of the Fourteenth Amendment. The judgment below should be affirmed.

Respectfully submitted,

DAVID FERLEGER
Counsel for Appellees

(footnote continued from preceding page)
judgment. *Preiser*, 411 U.S. at 849. However, where no such relief is sought or obtained, and where the state forum will decide the propriety of individual's confinement, the literal terms of the statute apply.

[133] Habeas corpus in state court is of no avail. The damage of commitment is already done by the time a child is likely to have the opportunity to consider such an avenue. If a child—without counsel or other representative—has the wherewithal to file a petition, any relief is too little, too late.

FOR ARGUMENT

Supreme Court, U.S.
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In the Supreme Court of the United States

No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,
Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,
Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania.

REPLY BRIEF FOR APPELLANTS

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ARGUMENT

I. THE PARENTAL DECISION TO SEEK MEDICALLY RECOMMENDED MENTAL HEALTH CARE FOR THEIR CHILD DOES NOT IMPLICATE THE CHILD'S CONSTITUTIONALLY PROTECTED INTEREST IN LIBERTY

A. Scope of the Lower Court's Order

Appellees contend that the ruling of the lower court only applies when "institutional" care has been medically recommended.[1] While the appellants certainly wish this were so, unfortunately the order's breadth is undeniable. In fact, appellees themselves sought a class which included the directors of *all* mental health and mental retardation facilities (956a). Thus, appellees' statement that they claimed no relief against these non-institutional directors is simply at odds with the plain facts.[2]

---

[1] Brief for Appellees at 52 n. 51. Appellees have never articulated their view of what is, and is not an "institution". Nevertheless appellants will use the term "non-institutional" to describe the home-like community-based facilities which currently are being provided in Pennsylvania. For a general description of Pennsylvania's program of providing community-based non-institutional alternative treatment modalities, see 3 Pa. Bull. 338 (Feb. 17, 1973). The high priority that is given to this form of residential treatment in Pennsylvania is set out in Knowlton, *Group Homes*, in National Association for Retarded Citizens, National Forum on Residential Services, 117 (1976).

[2] E.g. Brief for Appellees at 107 n. 129, where they recognized that they intended to include the directors of the approx-

In any event, at this point in the litigation, appellees' concession on this matter is of little value. Without question the terms of the District Court's injunction run against the directors of every mental health or retardation facility in Pennsylvania regardless of its characteristics.[3] In denying the appellants' Motion for a Stay, the District Court specifically ruled that its order was intended to include those children who were receiving care in non-institutional facilities.

In that Motion the actual numbers of children in the various institutional and non-institutional settings were detailed.[4] For example, appellants noted that there were 2,692 children receiving mental retardation care in privately operated facilities, 500 of whom were being served in group homes and apartments. Nevertheless the district court specifically included those 500 children within the scope of its order.[5] And finally, the District Court itself noted that, in its view, the underlying rationale for its decision, the stigma associated with mental illness, existed "regardless of the size of the institution or the actual conditions therein."[6]

Nevertheless the appellees' present position that they "make no claim regarding non-institutional care in this

imately 250 non-institutional facilities in the class of defendants they sued.

[3] 956a-959a; see also Defendants' Memorandum in Opposition to the United States' Request to Participate as "Litigating Amicus, Record No. 148 at 4, n. 6 (filed Feb. 27, 1978).

[4] Defendants' Motion for a Stay—Affidavit of G. Radke, Record No. 172 at ¶4, 5 and 6 (filed June 19, 1978).

[5] Memorandum and Order, Record No. 183 at 4 (filed July 17, 1978).

[6] 1070a.

case"[7] does shed some light on their aims in this suit. Rather than seeking protection from erroneous diagnoses of mental illness or retardation, appellees would have these adversary proceedings make the medical prescription of a specific type of treatment more difficult. In short, they are trying to effectuate "a reduced use of institutionalization."[8] As a policy matter it may indeed be true that the health professions or society in general will one day disapprove certain types of residential treatment for the mentally disabled which are currently in use. But until society acts this Court should reject the appellees' attempt to preempt the legislative processes by injecting meaningless and counterproductive adversarial hearings into the diagnostic process.

B. The Record Demonstrates That the Risk of Erroneous Medical Diagnoses or Recommendations for Residential Therapy Are Effectively Minimized by the Existing Procedures

---

Before a child is received into residential treatment in a Pennsylvania facility, great care is taken to assure the accuracy of the diagnosis of the child's condition as well as the propriety of the type of treatment which is recommended to the family. Nevertheless, referring to the retarded class representatives, the appellees state that "there is nothing in their medical records indicating that

[7] Brief for appellees at 52 n. 51.

[8] Id. at 78.

their condition required institutional care . . ."[9] Quite the contrary is true.

For example, the medical records of George S. show that prior to admission he received at least three separate and complete psychological evaluations. In addition, a neuro-psychiatrist then examined George and concluded that he needed residential therapy in an institutional setting.[10] Finally, prior to admission those seeking George's admission were specifically questioned regarding their utilization of available resources within the community.[11] Significantly, through all of this there was no evidence of divergence of opinion on the fact of George's severe level of retardation or his need for the residential therapy he continues to receive.

Appellees have taken a similar approach with respect to the mentally ill. For example, they contend that Francis B. was admitted to treatment on the basis of "unamplified allegations of 'difficulties adjusting to school' ".[12] However, once again they have turned a blind eye toward the medical records. In fact, Francis was completely ex-

[9] Brief for Appellees at 18.

[10] Defendants' Exhibit No. 3, Psychiatric Summary, N.G. Frignito (January 10, 1967). In addition to the three psychological pre-admission examinations noted by Dr. Frignito, George was enrolled in a complete program as an out-patient in the Pediatric Clinic at Children's Hospital. Moreover, prior to his admission, he was given still other specific psychological evaluations e.g. Houston Test for Language, Gesell Normative Summaries, and Merrill Palmer Infant Scale. Defendants' Exhibit No. 3, Psychological Report of J. Newman (December 31, 1968).

[11] Defendants' Exhibit 3, Confidential Waiting List Questionnaire, Part V, "Community Resources".

[12] Brief for Appellees at 15.

amined on at least three separate occasions and screened by the Haverford medical staff before he was accepted for treatment.[13]

This practice of carefully evaluating prospective admissions is not unique to these cases. To the contrary, the record demonstrates that not one of the appellees was admitted to treatment with less than three independent psychiatric or psychological examinations, each recommending residential care.[14] In this vein, it is significant that not one of the appellees has sought to terminate his or her treatment program. In short, there is absolutely no evidence of even one erroneous admission in Pennsylvania.

Finally, referring to certain portions of the record, the appellees assert that the parties stipulated to an edited listing of the purported reasons children have been admitted for residential care.[15] First, there had never been agreement between the parties on this point. In fact the appellees have relied upon nothing more than summaries of numerous admission records which *they themselves*

[13] Defendants' Exhibit No. 9, Pediatric—Neurological Examination, D. Baker, M.D. (October 10, 1973); Psychological Evaluation, G. Mott, M.A. (June 29, 1976 through July 2, 1976); Psychiatric Evaluation, Dr. McElfresh (June 8, 1976) (in that evaluation Dr. McElfresh specifically recommended residential therapy at Haverford State Hospital), and Admission Note, M. Marcovici, M.D. (August 16, 1976).

[14] Brief for appellants at 44.

[15] Brief for appellees at 4-6. Appellees only reference to the record for this contention is to 522a-523a which merely contains a list of patients whose complete medical records the parties agreed should be admitted as evidence (522a-523a). However, appellants surmise that appellees intended to refer to portions of the "Final Pre-Hearing Order" (274a).

prepared. Moreover, the appellants specifically objected to all of this material as being both argumentative and grossly misleading.[16] Thus, if one were to use appellees' technique, one might well assert that patient #00144 was admitted to residential care because "she is entering pubescence" (353a). However, among other things, this completely overlooks her medical diagnosis of severe retardation and brain disease (353a). In short, the record, in its entirety, demonstrates that not one of the appellees or the class they represent has been whimsically admitted to treatment. In fact the appellees themselves acknowledge the appropriateness of the residential care which they are receiving when they argue that they are not seeking its termination in this lawsuit.[17]

C. The Decision in Planned Parenthood of Missouri v. Danforth,[18] if Applicable at All, Supports the Appellants' Position

---

In *Danforth* this Court was confronted with a host of issues which formed the "logical and anticipated corrollary to *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 . . ."[19] One of those issues was the constitutionality of a Missouri statute which granted the parent of a pregnant minor the authority to unilaterally veto the decision of the mother and her physician

[16] 291a-297a contain the summaries. However appellants' specific objection to the use of anything less than the complete medical records is noted at 288a.

[17] Brief for appellees at 108.

[18] 428 U.S. 52 (1975).

[19] Id. at 72.

to terminate the pregnancy. Noting that the "very existence of the pregnancy already ha[d] fractured the family structure"[20] the court held that the rights of a "competent minor mature enough to have become pregnant" were impermissibly compromised by this statute.[21]

Each of the critical factors which existed in *Danforth* is absent here. First, there is no evidence that the interests of the parents and their children are "fundamentally in conflict."[22] In fact, as has already been pointed out, none of the appellees have taken issue with the wisdom of the joint decision between their parents and doctors regarding their treatment. Next, in contrast to *Danforth* the record here contains absolutely no evidence of the competence or maturity of these mentally ill and retarded children to select the appropriate medical care they should receive. The fact of the matter is that the Pennsylvania legislature has determined the contrary to be true. Moreover, that legislative determination has considerable support in the literature, and in any event is certainly not unreasonable.[23] In addition, the statute

[20] Id. at 75.

[21] Id.

[22] Id.

[23] One author, in agreement with Pennsylvania, has noted that minors under the age of fourteen should not be treated as adults in the context of an admission for treatment of mental illness. *The Mental Hospitalization of Children and the Limits of Parental Authority*, 88 Yale L.J. No. 1 at n. 112 and 113 (accompanying text) (galley proofs forwarded to the Clerk of this Court by the author on September 13, 1978). With respect to children under fourteen the commentator asserted that "parents may be—and in light of other considerations ought to be—given broad discretion. Although the pre-adolescent may well have preferences, he is not yet capable of making an intelligent choice" Id. at n. 117 (accompanying text).

in this case only authorizes parents to accept the medical recommendations for their child's treatment—not to veto such advice. Finally, the children here, unlike those in *Danforth*, have a variety of statutory opportunities to test the wisdom of this joint decision between the parents and physicians. E.g. 50 Pa. Stat. Ann. §4423(7) (right to independent psychiatric examination); 50 Pa. Stat. Ann. §4426, §7113 (habeas corpus); 50 Pa. Stat. Ann. §7206(b) (independent judicial review); and 3 Pa. Bull. 1840 (Sept. 1, 1973) (full judicial review for mentally retarded child over age thirteen); see also *Bellotti v. Baird*, 428 U.S. 132, 144-5, 147 (1976). Thus, viewed in the proper light, *Danforth* supports appellants' contention that the Pennsylvania statutes are constitutional.

CONCLUSION

On the basis of the foregoing arguments and authorities, as well as those contained in their main brief, appellants urge that the decision of the lower court must be reversed.

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No. 77-1715

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SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; D. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

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Appellees.

Appeal From The Judgment Of The United States District Court For The Eastern District Of Pennsylvania

BRIEF OF NATIONAL CENTER FOR LAW AND THE HANDICAPPED, AMERICAN COALITION OF CITIZENS WITH DISABILITIES, NATIONAL ASSOCIATION FOR RETARDED CITIZENS, AND EPILEPSY FOUNDATION OF AMERICA AMICI CURIAE

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In the Supreme Court of the United States

No. 77-1715

SECRETARY OF PUBLIC WELFARE OF PENNSYLVANIA et al.,

Appellants,

vs.

INSTITUTIONALIZED JUVENILES et al.,

Appellees.

Appeal From The Judgment Of The United States District Court For The Eastern District Of Pennsylvania

BRIEF OF NATIONAL CENTER FOR LAW AND THE HANDICAPPED, AMERICAN COALITION OF CITIZENS WITH DISABILITIES, NATIONAL ASSOCIATION FOR RETARDED CITIZENS, AND EPILEPSY FOUNDATION OF AMERICA AMICI CURIAE

INTEREST OF AMICI CURIAE

Amici curiae are organizations of handicapped persons, parents and professionals who are dedicated to ensuring the equal rights of handicapped persons through advocacy and educational services. All of these organizations have been involved in efforts to establish the delivery of appropriate services to children and adolescents.

Through their combined expertise, *amici* have provided information, authorities and argument in an attempt to

assist the Court in deciding the extremely important and complex issue presented in the case at Bar. *Amici* especially wish to assist the Court by placing the issues presented in their proper perspective and by suggesting what the ramifications of the Court's decision may be upon handicapped children.

The National Center for Law and the Handicapped is a research, advocacy and educational organization concerned with questions involving the legal rights of handicapped persons. It is sponsored by the Family Law Section of the American Bar Association, the National Association for Retarded Citizens, the University of Notre Dame School of Law, and the Council for the Retarded of St. Joseph County, Indiana. The Center assists attorneys, organizations and individuals through direct participation in cases and through research and consultation. Assistance is often provided to courts by the filing of *amicus curiae* briefs.

The American Coalition of Citizens with Disabilities is the largest national organization directed by disabled people to advocate on behalf of disabled Americans in all aspects of life and, in particular, on behalf of the civil and human rights of disabled persons. The Coalition is an umbrella organization consisting of seventy-five member associations of and for disabled people with a combined membership exceeding seven million.

The National Association for Retarded Citizens, with 300,000 adult members and over 1800 local chapters, is a voluntary organization devoted to promoting the welfare of mentally retarded children and adults. The Association represents a membership with interests and involvement in both institutional and community services issues. It makes available its information and expertise to assist individuals, professionals, organizations and the judicial system.

The Epilepsy Foundation of America is a non-profit organization established to advance the interests of the two million Americans with epilepsy through research, vocational programs, legal advocacy, professional awareness and public education programs. The Foundation's staff provides assistance to attorneys, legislators and organizations working in areas involving epilepsy through consultation, research, and testimony, and the Foundation attempts to assist courts by participating in selected cases as *amicus curiae.*

Amici have received consent from both the appellant and the appellee to file this brief.* Their consents are on file with the Clerk of the Supreme Court.

QUESTION PRESENTED BY AMICI CURIAE

Whether a state, which through its statutes permits a parent or guardian to civilly commit a minor to an institution for the mentally ill or mentally retarded, must, consistent with the due process clause of the fourteenth amendment, provide the child with a hearing on the need for commitment?

STATEMENT OF THE CASE

Plaintiff class members are mentally ill children below the age of fourteen and mentally retarded children below the age of nineteen, who have been committed to institutions for the mentally ill or mentally retarded by their parents or guardians pursuant to Pennsylvania statutes. A three-judge District Court for the Eastern District of Pennsylvania held the applicable statutes unconstitutional

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* The parties originally consented to the filing of an *amicus* brief by the National Center for Law and the Handicapped. Subsequently, they were informed of the participation by the other *amici*, and the parties raised no objections to their participation in the filing of this brief.

as violative of the due process clause of the fourteenth amendment because the statutes failed to provide these children with hearings as to their need for institutionalization. The decision followed closely a previous determination by the same court which had been vacated and remanded as moot, because of legislative changes in the state's statutes and regulations subsequent to the first decision. *Bartley* v. *Kremens,* 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded,* 431 U.S. 119 (1977).

The Pennsylvania statutes and regulations currently permit the institutional commitment of a mentally ill child by his or her parents or guardians. Within seventy-two hours of admission, the institution must formulate a treatment plan and justify the child's need for treatment. The child cannot request his or her release and receives no automatic hearing to determine the need for commitment. If a "responsible party" believes the child should not be institutionalized, he or she may petition the court for a hearing.

A mentally retarded child may be committed to an institution by parents or guardians with a referral from a pediatrician, general physician or psychologist. The admission must be reviewed by the director of the institution or his or her delegate. The child cannot request his or her release and receives no automatic hearing to determine the need for commitment. Each such child who is at least thirteen years of age is given notification of his or her rights within twenty-four hours of commitment and the telephone number of an attorney who can be called for representation. If the child or the attorney objects to institutionalization, a hearing on the need for commitment must be scheduled.

The district court ruled these procedures unconstitutional and enjoined their application. The court ruled that

the class of juveniles subject to commitment is entitled to: prior written notice; counsel or trained lay representative; personal presence with opportunity to be heard, to present evidence and testimony of witnesses, and to confront and cross-examine adverse witnesses; a standard of proof of clear and convincing evidence; a probable cause hearing within seventy-two hours; and, a full commitment hearing within two weeks of initial detention. The court noted that a waiver of these rights, except for notice and counsel, could be accepted by a neutral tribunal from a competent minor, after consultation with counsel, or from counsel on behalf of a minor not competent to act.

The decision was appealed and probable jurisdiction was noted by the Court, ... U.S. ....., 98 S. Ct. 3087 (1978).

SUMMARY OF ARGUMENT

The application of due process protections to a minor who is civilly committed to an institution through the actions of a parent or guardian must be determined by analyzing and balancing the interests affected by the process. In this brief, *amici* focus upon the threshold question of the necessity of a due process hearing and urge the Court to rule that due process requires such a hearing. *Amici* do not discuss the specific procedural components which the hearing should include, other than to urge the affirmance of the decision of the court below on the basis that the procedural protections granted therein are consistent with due process and do not unduly infringe upon the state's interests. *Amici* believe that the Court should wait for subsequent opportunities to consider the full extent of the fourteenth amendment's impact upon the civil commitment process. *E.g. State* v. *Addington,* 557 S.W. 2d 511 (Tex. 1977), *prob. juris. noted,* ..... U.S. ....., 98 S. Ct. 1604 (1978) (No. 77-5992) (appropriate standard of proof in civil commitments).

In Part I of this brief, *amici* discuss the minor's liberty interest which is abridged by civil commitment. *Amici* argue that this liberty interest clearly invokes the application of the due process clause of the fourteenth amendment. The Court has on numerous occasions recognized the serious consequences which the civil commitment process places upon a person's liberty. *O'Connor* v. *Donaldson,* 422 U.S. 563 (1975); *Jackson* v. *Indiana,* 406 U.S. 715 (1972); *Humphrey* v. *Cady,* 405 U.S. 504 (1972). As the Court has recognized in its decisions involving the juvenile court system, the liberty interest is not diminished by merely labeling the procedures "civil." *Amici* contend that the deprivation of a minor's liberty through civil commitment is substantially similar to the deprivation of a minor's liberty in juvenile delinquency proceedings, where the Court has invoked the application of due process protections. *Cf. In re Winship,* 397 U.S. 358 (1970); *In re Gault,* 387 U.S. 1 (1967).

As an integral part of due process, the Court has consistently required a hearing prior to the abridgement of fundamental interests involving liberty and property. In juvenile cases and in adult civil commitments, the necessity of full judicial hearings has been recognized. But even in situations involving interests much less substantial, the Court has established the basic requirement of a hearing. Thus, revocation of parole or probation, termination of welfare benefits, suspension from public school, and termination of tenured employment are but a few of the situations in which the Court has mandated hearings. *Amici* submit that the minor's significant liberty interest in the case at Bar is as compelling as other interests for which hearings are required under the fourteenth amendment.

Having outlined the importance of the minor's liberty interest, Part II of this brief turns to the balancing of

the competing interests in the commitment process: the private liberty interest, the risk of an erroneous deprivation of that interest, and the state's interest. *Amici* contend that the child's liberty interest is fundamental and that the risk of an erroneous deprivation of that interest is high. It is argued that a due process hearing would substantially protect the private interest, as well as greatly assist in minimizing the risk of error. On the other hand, *amici* illustrate that the governmental interest is minimal and therefore, on balance, a hearing should be mandated.

The minor's interest in being free from bodily restraint in its most basic form is obvious. Commitment results not only in this loss of freedom, but also in the loss of numerous other basic rights, including first amendment rights. In addition, the adverse collateral aspects of institutionalization are significant. An institutionalized child faces loss of developmental skills, psychological deprivations, and stigmatization; institutionalization can negatively affect an individual's future life, including his or her educational and employment opportunities.

Yet, these serious ramifications arise from a process fraught with the possibility of error. *Amici* submit information illustrating that psychiatry and psychology are not exact sciences; thus, the diagnosis of a child as mentally ill or the labeling of a child as mentally retarded may be erroneous or misleading. *Amici* then illustrate that the decision to commit is a fact-finding process and not merely a determination made by experts. The existence of a mental disability is only a threshold requirement for commitment; facts, which are often subjective and disputable, indicating the specific behavior or actions of the child are the key to the determination of the need for commitment. In addition, in order to minimize the risk of error, a full exploration of alternatives to commitment is needed to

ensure that a child does not suffer the adverse effects of institutionalization when a more appropriate placement exists. *Amici* argue that these kinds of findings are uniquely suited to determination in a hearing.

Weighing against the requirement of hearings are certain governmental interests, including the preservation of the family unit and fiscal concerns. However, *amici* argue that these interests are minimal and that the state's parens patriae concerns for handicapped children support the desirability of hearings. Under its parens patriae power, the state must act in the best interests of the child. Thus, in considering the commitment of the child, the state's interest is in protecting the child's liberty and in preventing harm to the child by minimizing the risk of inappropriate commitment.

The arguments favoring due process hearings are not overcome by the state's interest in preserving the family unit. Once the parental decision is made to disrupt the family unit through commitment of the child, the integrity and the cohesiveness of the family unit have been significantly weakened. *Cf. Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976).

As for fiscal implications, *amici* submit that the state has already established procedures for civil commitment hearings; therefore, *amici* argue that spiraling costs may not necessarily result from an affirmance of the lower court's decision. *Amici* also point out that the lower court envisioned the waiver of the right to a hearing in certain situations. Finally, even if more hearings result from this Court's ultimate determination, *amici* assert that, because the hearing process will insure against erroneous institutional commitments, any increase in the administrative cost of providing hearings will be offset by the sav-

ings realized in the state's expenditures for institutional care.

In Part III of this brief, *amici* examine the commitment system currently provided by the state and argue that it is an insufficient substitute for a due process hearing. The procedures, which place a burden upon the child, or in some circumstances upon an undetermined "responsible person," to initiate hearing requests, do not provide adequate due process protections. *Amici* contend that for many institutionalized children, these procedures are virtually meaningless. Merely requiring a physician's referral and a review by the institutional director does not suffice. *Amici* illustrate that these requirements are not meaningful because physicians of all specialties are frequently not knowledgable about the needs of a handicapped child; therefore, they lack the expertise to make informed decisions in the child's best interests. Additionally, the institutional director, who frequently acts through a delegate, is not in a position to objectively review the proposed commitment when faced with the parent(s)' application for institutionalization.

Finally, *amici* assert that sanctioning the state's informal commitment procedures will have unfortunate consequences for handicapped children, by permitting the commitment of children when institutionalization is not in their best interests. *Amici* fear that the widespread usage of institutionalization will continue to occur without the establishment of a formal procedural mechanism, wherein the necessity for commitment and the availability of more appropriate community alternatives are carefully scrutinized. *Amici* believe that hearings are the only appropriate procedural mechanism to insure against the deprivation of basic rights, the suffering of irremedial harm, and the stigmatization for life which can unnecessarily result from the civil commitment of children.

ARGUMENT

I.

CIVIL COMMITMENT INFRINGES UPON AN INDIVIDUAL'S FUNDAMENTAL INTEREST IN LIBERTY, THUS NECESSITATING THE APPLICATION OF DUE PROCESS PROTECTIONS INCLUDING THE RIGHT TO A HEARING.

The determination of that process which is due under the requirements of the due process clause of the fourteenth amendment requires an analysis and balancing of the competing interests of the parties.[1] *Mathews* v. *Eldridge,* 424 U.S. 319 (1976). However, prior to reaching the need to weigh these various interests, a threshold inquiry must be made to determine whether the interest which seeks due process protection falls within the scope of the fourteenth amendment's concept of liberty and property. *Board of Regents* v. *Roth,* 408 U.S. 564 (1972).

[1] This case involves only the issue of whether the relief ordered by the lower court is a constitutionally permissible infringement upon Pennsylvania's legislative scheme for civil commitments. Thus, this Court need only address the question of whether the hearing procedures ordered below are consistent with the fourteenth amendment's proscription of liberty deprivations by the states.

The desirability of more stringent safeguards, such as judicial hearings (rather than administrative hearings), mandatory provision of legal counsel (rather than lay advocates), or a reasonable doubt standard of proof (rather than a clear and convincing evidence standard) are not matters which are at issue in the case at Bar. The full extent of the specific requirements of due process should be addressed in future cases. *E.g. State* v. *Addington,* 557 S.W.2d 511 (Tex. 1977), *prob. juris. noted,* ..... U.S. ....., 98 S. Ct. 1604 (1978) (No. 77-5992) (appropriate standard of proof in civil commitments).

Over a half-century ago, the Court enunciated a far-reaching approach to the fourteenth amendment's protection of "liberty."

> While this Court has not attempted to define with exactness the liberty thus guaranteed, the term has received much consideration and some of the included things have been definitely stated. Without doubt, it denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men.

Meyer v. *Nebraska,* 262 U.S. 390, 399 (1923) (citations omitted). More recently Justice White has reaffirmed this expansive view of "liberty." "In a constitution for a free people there can be no doubt that the meaning of 'liberty' must be broad indeed." *Moore* v. *City of East Cleveland, Ohio,* 431 U.S. 494, 546 (1977) (White J., dissenting), citing *Board of Regents* v. *Roth,* 408 U.S. 564, 572 (1972).

Amici assert that the individual's interest in liberty is sufficiently infringed upon by civil commitment to require the application of procedural due process which mandates the right to a hearing.

A. Civil Commitment Seriously Abridges a Minor's Fundamental Interest in Liberty.

1. The Court Has Previously Recognized the Deprivation of Liberty Which Occurs as a Result of the Commitment Process. While the Court has never directly ruled on the substantive or procedural requirements which are constitutionally mandated in the civil commitment process, the Court has recognized in a series of decisions that the civil

commitment of an individual involves a serious deprivation of liberty.

In the most recent decision involving an involuntarily committed mental patient, the Court narrowed the issue to an "important question concerning every man's constitutional right to liberty." *O'Connor* v. *Donaldson,* 422 U.S. 563, 573 (1975). The Court held that

> a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.

Id. at 576. In his concurring opinion, Chief Justice Burger emphasized the overriding interest in liberty held by a mentally ill individual who is nondangerous and capable of surviving safely in freedom. *Id.* at 578 (Burger C.J., concurring).[2]

"Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power [to involuntarily hospitalize] have

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[2] "There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law." 422 U.S. at 580 (Burger C.J., concurring). *See also* Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives,* 70 Mich. L. Rev. 1107, 1158 (1972). "It is indeed hard to accept that there can be any 'fundamental personal liberty' . . . more fundamental than personal liberty itself and personal liberty is, of course, what is at risk in its most literal sense for the mentally ill." Among the fundamental interests which Chambers argues are affected by civil commitment are the rights to travel, of free association, to peaceably assemble, to communicate and receive communications, to exercise religious beliefs and to maintain one's privacy, though overriding is the right not to be physically confined.

not been more frequently litigated." *Jackson* v. *Indiana,* 406 U.S. 715, 737 (1972). In the case at Bar, the Court is asked to decide whether the state must provide minors with certain procedural safeguards in order to justify "a massive curtailment of liberty."[3] *Humphrey* v. *Cady,* 405 U.S. 504, 509 (1972).

At stake is an individual's liberty, "an interest of transcending value." *Speiser* v. *Randall,* 357 U.S. 513, 525 (1958). *Amici* argue that the preservation of that liberty interest requires that due process protections attach.[4] To

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[3] It is of no importance that the procedure is labeled "voluntary" rather than "involuntary." Semantic usage cannot mask the reality that the minor is not giving his or her consent to the liberty deprivation. The question of whether to apply due process can only be answered by an inquiry into the substance of the deprivation. *Cf. In re Gault,* 387 U.S. 1 (1967). The reality is that a minor is deprived of the fundamental right to liberty and involuntarily placed in an institutional environment through the actions of a parent or guardian with the concurrence of the state and under the legal auspices of the state. As several courts have noted, confinement of an individual to an institution without his or her consent and without presenting realistic alternatives to the individual constitutes involuntary confinement. *Halderman* v. *Pennhurst State School and Hospital,* 446 F. Supp. 1295, 1311 (E.D. Pa. 1977); *Griswold* v. *Riley,* No. CIV 77-144 PHX-CAM (D. Ariz. July 15, 1977); *New York State Association for Retarded Children* v. *Rockefeller,* 357 F. Supp. 752, 762 (E.D.N.Y. 1973); *Horacek* v. *Exon,* 357 F. Supp. 71, 74 (D. Neb. 1973).

[4] The Court of Appeals for the District of Columbia, having scrutinized the civil commitment process, concluded:

> There can no longer be any doubt that the nature of the interests involved when a person sought to be involuntarily committed faces an indeterminate and, consequently, potentially permanent loss of liberty and privacy accompanied by the loss of substantial civil rights (the loss of which frequently continues even if his liberty is restored) is "one within the contemplation of the 'liberty and property' language of the Fourteenth Amendment."

In re Bailay, 482 F.2d 648, 655 (D.C. Cir. 1973), citing *Morrissey* v. *Brewer,* 408 U.S. 471, 481 (1972).

permit the state-sponsored deprivation of an individual's liberty upon the consent of another person, without providing the individual who is subject to the civil commitment an opportunity for a hearing, does not afford sufficient due process.

2. The Liberty Interest Affected by Civil Commitment Is as Substantial as the Liberty Interest Infringed Upon in Other "Civil" Proceedings Involving Minors. The juvenile justice system historically provided only informal standards and procedures, based upon the rationale that the proceedings were civil in nature and based upon an assumed benevolent intent to rehabilitate wayward youth. In numerous respects, the former policies of administration of juvenile justice parallel the current civil commitment practices in many states.

In 1967, the Court looked beyond the asserted reasoning to analyze the effect of the juvenile process upon the individual.

> Ultimately, however, we confront the reality of that portion of the Juvenile Court process with which we deal in this case. A boy is charged with misconduct. The boy is committed to an institution where he may be restrained of liberty for years. It is of no constitutional consequence and of limited practical meaning—that the institution to which he is committed is called an Industrial School. The fact of the matter is that, however euphemistic the title, a "receiving home" or an "industrial school" for juveniles is an institution of confinement in which the child is incarcerated for a greater or lesser time. His world becomes "a building with whitewashed walls, regimented routine and institutional hours. . . ." Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by guards, custodians, state employees, and "delinquents" confined with him for anything from waywardness to rape and homicide.

In re Gault, 387 U.S. 1, 27 (1967) (footnotes omitted).

Rather than relying upon the labels attached to the procedures, the Court struck to the heart of the matter: commitment means depriving a person of his or her liberty. The Court applied the basic principles of due process to juvenile proceedings, reasoning that

> [t]o hold otherwise would be to disregard substance because of the feeble enticement of the "civil" label-of-convenience which has been attached to juvenile proceedings . . . . For this purpose, at least, commitment is a deprivation of liberty. It is incarceration against one's will, whether it is called "criminal" or "civil."

Id. at 49-50.

Three years later, the Court reiterated its decision in *Gault* and extended its reasoning to require a reasonable doubt standard of proof in juvenile proceedings. *In re Winship*, 397 U.S. 358 (1970). The Court emphasized that the "'civil' label-of-convenience" and the desire "not to punish, but to save the child" had been rejected as a basis for not applying due process.

> We made clear in that decision that civil labels and good intentions do not themselves obviate the need for criminal due process safeguards in juvenile courts, for "[a] proceeding where the issue is whether the child will be found to be 'delinquent' and subjected to the loss of his liberty for years is comparable in seriousness to a felony prosecution."

Id. at 365-66, quoting *In re Gault*, 387 U.S. 1, 36 (1967).

In his concurring opinion in *Winship*, Justice Harlan made it clear that the Court's decision turned upon the consequences of the proceeding to the juvenile.

> First, and of paramount importance, a factual error here, as in a criminal case, exposes the accused to a complete loss of his personal liberty through a state-imposed confinement away from his home, family, and friends. And, second, a deliquency determination, to some extent at least, stigmatizes a youth in that it is

> by definition bottomed on a finding that the accused committed a crime. Although there are no doubt costs to society (and possibly even to the youth himself) in letting a guilty youth go free, I think here, as in a criminal case, it is far worse to declare an innocent youth a delinquent.

Id. at 374 (Harlan J., concurring).

The focal point of the Court's analysis in *Gault* and *Winship* was clearly upon the restrictions which the legal process placed upon the individual's liberty.[5] *Amici* argue that a similar approach to assessing the effects of the civil commitment process upon juveniles supports the conclusion that the individual's liberty interest is infringed upon. *Amici* assert that the liberty interest at stake in the case at Bar is similar to, and as important as, the liberty interest affected by the juvenile justice system. Therefore, the state's power to interfere with that liberty interest is subject to the restrictions of the due process clause.[6]

[5] Similarly, in *Breed* v. *Jones,* 421 U.S. 519 (1975), the Court followed the holdings in *Gault* and *Winship* to apply the double jeopardy clause to juveniles subject to transfer from juvenile court to adult court.

[6] The striking similarity between the liberty interests in juvenile proceedings and those in the civil commitment process formed the basis for the holding of the United States Court of Appeals for the Tenth Circuit that a nine year old child committed to a training school for "feeble-minded and epileptic children" had a right to counsel.

> [T]he liberty of an individual is at stake, and we think the reasoning in Gault emphatically applies. It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabiiitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process.

Heryford v. *Parker,* 396 F.2d 393, 396 (10th Cir. 1968).

B. The Right To Be Heard Is an Integral Component of Due Process Which Has Been Consistently Required by the Court Prior to the Deprivation of Liberty and/or Property Interests.

In imposing constitutional restraints upon the state's infringement of liberty interests through civil juvenile proceedings, the Court mandated that a hearing be provided to satisfy the requirements of due process.[7] *In re Gault,* 387 U.S. 1 (1967). Similarly, in decisions involving the civil commitment process, the Court has recognized the inherent importance of a hearing. In *Baxstrom* v. *Herold,* 383 U.S. 107 (1966), the Court held that individuals who were committed at the expiration of their penal sentences were denied equal protection when they were not provided with a jury review or a judicial determination of dangerousness, both of which were afforded to other persons in the civil commitment process. The Court rejected the state's contention that groups of persons could be differentiated and that one group could be denied a hearing solely on the basis that its members were nearing the end of their prison terms.

Likewise, in *Jackson* v. *Indiana,* 406 U.S. 715 (1972), the Court held that a person found incompetent to stand trial could not be held more than a reasonable period of time to determine future capacity to stand trial, unless the individual was civilly committed pursuant to a state law which provided for a hearing.

> If criminal conviction and imposition of sentence are insufficient to justify less procedural and substantive protection against indefinite commitment than that gen-

[7] The Court held that the hearing must include the following procedural safeguards: notice of the charges; right to counsel; right to confrontation and cross-examination of witnesses; and, the privilege against self-incrimination. The Court later added the requirement that the proof satisfy a reasonable doubt standard. *In re Winship,* 397 U.S. 358 (1970).

erally available to all others, the mere filing of criminal charges surely cannot suffice.

Id. at 724.

The Court's refusal to condone liberty deprivations without a hearing, based upon a previous criminal conviction and penal sentence or based upon the filing of a criminal charge, is a recognition of the importance of the individual's interest. Similarly, *amici* submit that the status of minority cannot be a sufficient justification for denying a hearing which is otherwise provided to adults.[8] A hearing, aimed at determining the factual basis for the deprivation of liberty, is just as essential for a minor as for an adult in the civil commitment process.[9]

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[8] *Cf. Baxstrom* v. *Herold,* 383 U.S. 107, 115 (1966). The capriciousness of the classification employed by the State is thrown sharply into focus by the fact that the full benefit of a judicial hearing to determine dangerous tendencies is withheld only in the case of civil commitment of one awaiting expiration of penal sentence." This does not mean that in all situations a rational distinction cannot be drawn. The Court need not decide and *amici* do not address the question of proper procedures to be followed in the state's provision of respite care. This should initially be left to the discretion of the state, subject to judicial review should the necessity arise.

[9] In *Jackson* v. *Indiana,* 406 U.S. 715 (1972), the Court indicated that Jackson was not afforded formal commitment proceedings aimed at discovering the factual basis for the liberty deprivation. "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." *Id.* at 738. Due process must attach regardless of the age of the individual who is subject to commitment. The minor's liberty interest parallels closely the liberty interest of an adult facing involuntary commitment. The physical restraint, stigma and other deprivations entailed in institutionalization are the same as those encountered by adults. As the Court recognized in *Gault, supra,* the incarceration of juveniles requires due process protections which are similar to those provided to similarly situated adults—despite legislative nomenclature (i.e., "civil"/"criminal" or "minor voluntary"/"involuntary").

Moreover, the Court has previously required the provision of a hearing in matters involving interests less fundamental than the liberty interests implicated by civil commitment. In *Morissey* v. *Brewer,* 408 U.S. 471 (1972), the Court considered the question of whether a convicted criminal on parole status had the right to a hearing prior to the revocation of parole. The Court held that revocation of parole abridged a liberty interest contemplated by the due process clause of the fourteenth amendment, albeit only a conditional liberty interest, and that a hearing prior to revocation was constitutionally required. Protections for conditional liberty were later further extended when the Court required a hearing prior to the revocation of probation.[10] *Gagnon* v. *Scarpelli,* 411 U.S. 778 (1973).

The Court has not limited the due process protection of liberty "to mere freedom from bodily restraint," *Bolling* v. *Sharpe,* 347 U.S. 497, 499 (1954), but has extended the requirement of a hearing to liberty interests involving one's good name, reputation, honor or integrity. In *Goss* v. *Lopez,* 419 U.S. 565 (1975), the nature of a student's liberty interest in his or her reputation and standing with fellow pupils and teachers required a hearing prior to the student's suspension from a public high school for misconduct, even though the suspension was limited to ten

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[10] *See also* Friendly, *Some Kind of Hearing,* 123 U. Pa. L. Rev. 1267 (1975), commenting upon *Morrissey* and *Gagnon.*

> Deprivation of liberty, even conditional liberty, is the harshest action the state can take against the individual through the administrative process. The Supreme Court thus was right in demanding a very high level of procedural protection and in setting out the required procedures in detail. Civil commitment warrants a similarly high place.

Id. at 1296.

days. Also involved was the student's property interest in educational benefits which required due process protection.

Similarly, in employment cases, the Court has viewed the combined liberty interest involving reputation and stigma with a property interest to require the provision of prior hearings. The Court in *Perry* v. *Sindermann*, 408 U.S. 593 (1972), and *Board of Regents* v. *Roth*, 408 U.S. 564 (1972), held that a public educational institution may not dismiss a teacher without a hearing when the teacher is tenured or when the dismissal involves a stigma which can impair the ability to obtain future employment.

Triggering this broad application of due process was the Court's decision in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970). There, the Court made clear that an evidentiary hearing prior to the termination of welfare benefits was constitutionally required to protect a fourteenth amendment property interest.

The Court later extended this protection of property interests to: the revocation of a driver's license, *Bell* v. *Burson*, 402 U.S. 535 (1971); the repossession of a chattel through replevin, *Fuentes* v. *Shevin*, 407 U.S. 67 (1972); and, the loss of a prisoner's good-time credits, *Wolff* v. *McDonnell*, 418 U.S. 539 (1974).

In several instances in which the Court has failed to apply due process to require a hearing, the Court has stressed the availability of elaborate administrative procedures or the possibility of regaining the otherwise protected interests retroactively if the individual was successful on the merits of the claim. In *Arnette* v. *Kennedy*, 416 U.S. 134 (1974), a nonprobationary federal employee could be discharged for cause without a prior hearing where the employee was entitled to a subsequent evidentiary hearing which would result in reinstatement and backpay if the employee prevailed. In *Mathews* v. *Eldridge*, 424 U.S. 319 (1976), the Court held that an evidentiary hearing was not required prior to the termination of social security disability payments, because elaborate administrative procedures were provided which assured the right to an evidentiary hearing and to judicial review subsequent to the termination of disability benefits.

Amici argue that the right of a minor to be free from bodily restraint, to protect his or her reputation, and to guard against the adverse stigma of commitment are substantial liberty interests which can only be protected by the requirement of a hearing in civil commitments. Where due process requires such a result when liberty and property interests are at stake in parole and probation revocations, public school suspensions, public employment, welfare benefits, drivers' licenses, replevin actions and good-time credits, similar procedural protections must attach to the liberty interest abridged by civil commitment. *Amici* submit that the liberty interest of a minor committed to an institution is more significant than many of the interests which the Court has previously protected by requiring prior hearings.

Additionally, the civil commitment process provides no method for the restoration of the liberty interests which are abridged. Hearings must, therefore, be required in order to adequately protect the individual's fundamental interests.

II.

THE PROVISION OF A HEARING IS MANDATED BY BALANCING THE MINOR'S INTERESTS AND THE RISK OF AN ERRONEOUS DEPRIVATION OF LIBERTY AGAINST THE GOVERNMENTAL INTEREST IN CIVILLY COMMITTING THE MINOR TO AN INSTITUTION.

A. Commitment of a Minor to an Institution Deprives the Individual of the Fundamental Right to Freedom, Adversely Stigmatizes Him or Her for Life, and Abridges Numerous Other Constitutionally Protected Rights.

The nature and extent of due process protections which should attach to the process of committing a minor reflect in part the nature and extent of the infringement upon liberty which results. The expansive deprivations which occur in the commitment of minors have been vividly delineated by the three-judge federal court in *J. L. and J. R.* v. *Parham*, 412 F. Supp. 112 (M.D. Ga. 1976), *prob. juris. noted*, 431 U.S. 936 (1977), *reargument ordered*, ... U.S. ....., 98 S. Ct. 761 (1978).

> [T]his case raises the most important question of every child's constitutional right to liberty, not only the liberty that includes freedom from bodily restraint, *Meyer* v. *Nebraska*, 262 U.S. 390 (1922), but also the liberty that includes the freedom of an ordinary, everyday child in these United States of America—the freedom to live with mothers, fathers, brothers and sisters in whatever the family abode may be; the freedom to be loved and to be spanked; the freedom to go in and out the door, to run and play, to laugh and cry, to fight and

> fuss, to stand up and fall down, to play childish games; the freedom to go to school and to frolic with school mates; the freedom to go to Sunday School and church; the freedom to watch and listen or not to watch and listen to television; the freedom to buy candy at the corner store; the freedom to be a normal child in a normal household cared for by normal parents.

Id. at 136. Thus the rights affected by the commitment process include the right to be free from restraint in its most basic form, as well as numerous first amendment rights.[11] Restrictions on freedom of movement, loss of privacy and denial of many basic civil rights are commonplace.[12]

Beyond the most apparent deprivations of liberty interests are the collateral aspects of institutionalization—the stigma of mental disability and the discrimination which result from being a former "inmate." These deprivations are not de minimis. The judiciary has acknowledged the stigma associated with intitutionalization,[13] as have a num-

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[11] The Court has previously extended first amendment protections to juveniles. *Tinker* v. *Des Moines School District*, 393 U.S. 503 (1969).

[12] For a detailed discussion of these numerous deprivations, see Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1193-1200 (1974).

[13] *See e.g. In re Ballay*, 482 F.2d 648, 668-69 (D.C. Cir. 1973); *Lessard* v. *Schmidt*, 349 F. Supp. 1078, 1089 (E.D. Wis. 1972), *remanded*, 414 U.S. 473 (1974), *reinstated*, 379 F. Supp. 1376 (E.D. Wis. 1974), *remanded*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976). *Cf. In Re Winship*, 397 U.S. 358 (1970), recognizing the stigma attached to a finding of juvenile delinquency.

ber of commentators.[14] Prior institutionalization can adversely affect one's search for employment[15] and one's

[14] *See e.g.* Goffman, Asylums 355-56 (1961), discussing stigma from external sources as well as a form of internal stigma which creates an alienation from society. *See also* Teitelbaum and Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application* 30-32 (to be published in 12 Fam. L.Q. 153, prepublication manuscript on file in the Library of the Supreme Court); *Developments in the Law, supra* note 12.

> Along with these official deprivations, a former mental patient may suffer from the social opprobrium which attaches to treatment for mental illness and which may have more severe consequences than do the formally imposed disabilities.

Id. at 1200.

The mere fact of discharge may not alter society's perception of mentally disabled individuals; once diagnosed, an individual does not easily shed the label given. *See e.g.* Rosenhan, *On Being Sane In Insane Places,* 13 Santa Clara Lawyer 379 (1973), where pseudopatients, after obtaining their release from a mental institution, were not described as having recovered or having never been schizophrenic, but were all released with the psychiatric notation "schizophrenia, in remission." *See also In re Ballay,* 482 F.2d 648, 668-69 (D.C. Cir. 1973).

[15] "One commentator, noting that 'former mental patients do not get jobs,' has insisted that '[i]n the job market, it is better to be an ex-felon than ex-patient.'" *Lessard* v. *Schmidt,* 349 F. Supp. 1078, 1089 (E.D. Wis. 1972), *remanded,* 414 U.S. 473 (1974), *reinstated,* 379 F. Supp. 1376 (E.D. Wis. 1974), *remanded,* 421 U.S. 957 (1975), *reinstated,* 413 F. Supp. 1318 (E.D. Wis. 1976), quoting Testimony of Bruce Ennis, Hearings Before the Senate Subcommittee on Constitutional Rights, 91st Congress, 2d Sess. at 284 (1970). The federal government, by enacting the Rehabilitation Act of 1973, 29 U.S.C. § 701 et seq., has attempted to combat discrimination, including employment discrimination, against individuals labeled mentally disabled. *See also Doe* v. *Hampton,* No. 76-1090 (D.C. Cir. Sept. 14, 1977); *Spencer* v. *Toussaint,* 12 E.P.D. ¶ 11,112 (E.D. Mich. 1976).

educational pursuits.[16]

The curtailment of liberty which results from civil commitment can, in some instances, result in greater deprivation for minors than for adults.[17] The effect of civil commitment upon children may be magnified, because it is in their childhood years that they are most dependent upon familial relationships and support; hence, they are extremely vulnerable to the harms of institutionalization.[18] Separation from parents at an early age can adversely affect critical areas of development.[19] Even a short com-

[16] *See e.g. Doe* v. *New York University,* 442 F. Supp. 522 (S.D. N.Y. 1978). Recent federal legislation is aimed at combatting discrimination in education. The Education for All Handicapped Children Act, 20 U.S.C. § 1401 et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794.

[17] Even if the child's interests did not reach the level of an adult's interests, the burden upon the state to justify its differentiation in procedural protections would be great. "So wide a gulf between the State's treatment of the adult and of the child requires a bridge sturdier than mere verbiage, and reasons more persuasive that cliché can provide." *In re Gault,* 387 U.S. 1, 29-30 (1967).

[18] The loss of developmental skills is perhaps the greatest harm. Teitelbaum and Ellis, *supra* note 14, at 32, citing voluminous scientific literature on the adverse effects of institutionalization upon intelligence quotient, verbal and motor skills, and social competence. As one commentator notes: "The stakes are high: a child's life may be ruined by hasty, ill-informed procedures." Holladay, *Due Process Limitations on Parental Rights to Commit Children to Mental Institutions,* 48 U. Colo. L. Rev. 235, 266 (1977).

[19] Scheerenberger, Deinstitutionalization and Institutional Reform 20 (1976).

> The single most powerful factor in the personality development of the child is the happiness and stability of the home in which he spends his early years. We do not mean by such a home that it need be characterized by a high level of education, a high

(footnote continued)

mitment may be traumatic for the child; depending on the child's developmental stage, a few days of separation from one's parents can lead to despair and profound feelings of helplessness and deprivation.[20] In addition, commitment will invariably disrupt the child's formal education in an adverse manner.[21]

Clearly, civil commitment involves infringements of liberty beyond basic physical restraint.

> [C]onsiderable harms . . . may befall the individual because of involuntary confinement. These may include stigmatization; collapse of self-esteem, separation from family and community . . . and impairment of future employment prospects, as well as, in our current state of institutional care, a not insubstantial chance of brutalization or mere physical deterioration in the total institutions to which many such persons are sent.[22]

(footnote continued)

> standard of living, or even a high degree of success in meeting its problems, important and desirable as these may be. We mean a happy and stable home, one in which there is affection and consideration among the members for each other; one in which the individual members are emotionally secure and in mental health (Dewey and Humber, 1951).

Id. at 19.

[20] Goldstein, Freud and Solnit, Beyond the Best Interests of the Child 40-42 (1973). "A child will experience a given time period not according to its actual duration, measured objectively by calendar and clock, but according to his purely subjective feelings of impatience and frustration." *Id.* at 41.

[21] Under the Education for All Handicapped Children Act, 20 U.S.C. § 1401 et seq., each handicapped child must have a carefully planned and detailed individualized education plan.

[22] Stone, Mental Health and Law: A System in Transition 48-49 (1975) (published by The National Institute of Mental Health).

Amici assert that the individual's liberty interests in civil commitment are both substantial and diverse. Adequate protection for those interests cannot exist absent procedural due process rights which include the right to a hearing.

B. The Provision of Hearings Will Minimize the Risk of Erroneous Commitments of Minors to Institutions.

The right to a hearing holds a special position within the protections granted by the due process clause.

> Many controversies have raged about the cryptic and abstract words of the Due Process Clause but there can be no doubt that at a minimum they require that deprivation of life, liberty or property by adjudication be preceded by notice and opportunity for hearing appropriate to the nature of the case.

Mullane v. *Central Hanover Trust Co.*, 339 U.S. 306, 313 (1950). The value of a hearing cannot be seriously questioned where substantial individual interests are at stake.

> No better instrument has been devised for arriving at truth than to give a person in jeopardy of serious loss notice of the case against him and opportunity to meet it. Nor has a better way been found for generating the feeling, so important to a popular government, that justice has been done.

Joint Anti-Fascist Refugee Committee v. *McGrath*, 341 U.S. 123, 171-72 (1951) (Frankfurter J., concurring). The Court has unequivocally stated that "[w]hen protected interests are implicated, the right to some kind of prior hearing is paramount." *Board of Regents* v. *Roth*, 408 U.S. 564, 569-70 (1972).

The decision to commit a minor is based upon unique and difficult considerations; the questions raised and the issues to be resolved are complex. Thus, the resultant risk

of erroneously committing a minor to an institution is very high. *Amici* submit that the due process clause envisions the provision of hearings to resolve issues such as those addressed in the civil commitment process.

1. Psychiatry and Psychology Are Inexact Sciences. The threshold question prior to a civil commitment is whether the minor is mentally ill or mentally retarded. *Amici* argue that this inquiry is not easily resolved and that the "experts" relied upon are often in disagreement.

If an application is filed to commit a mentally ill child based upon his or her parent(s)' perception of the minor's actions or behavior, a psychiatrist must diagnose that child to determine the basis for state intervention. To justify commitment, a specific mental illness must be found by competent medical examinations.

However, as Chief Justice Burger astutely recognized over a decade ago, psychiatrists and psychologists "may be claiming too much in relation to what they really understand about the human personality and human behavior."[23] Exclusive reliance upon their opinions in a decision to commit may lead to a high degree of erroneous commitment.

A recent article which reviewed the available literature on the question of psychiatric reliability[24] concluded:

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[23] Burger, *Psychiatrists, Lawyers, and the Courts*, 28 Fed. Prob. 37 (1964).

[24] The concept of reliability is measured by the "probability or frequency of agreement when two or more independent observers answer the same question." Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Calif. L. Rev. 693, 697 (1974). The reliability of the diagnosis thus defines the degree of consistency among opinions of psychiatrists concerning a person's condition.

"Studies on psychiatric diagnosis highlight psychiatry's lack of precise definitions and the inability of psychiatrists to apply these definitions in a reliable and consistent manner."[25] Similarly, another reviewer of the relevant literature observed: "With regard to reliability of diagnosis, the most common research findings indicate that, on the average, one cannot expect to find agreement in more than about 60% of cases between two psychiatrists."[26]

The diagnosis of an allegedly mentally retarded child raises similar questions of accuracy. Again, a threshold finding of mental retardation is required to invoke the commitment power; without such a finding, no justification for institutionalization can arise. As with allegedly mentally ill children, many children who are labeled mentally retarded may not be mentally retarded, because testing is not always accurate and because that which is tested for may not accurately describe the child's true functioning ability.

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[25] Albers, Pasewark & Meyer, *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 Cap. U.L. Rev. 11, 15 (1976), and studies cited therein.

[26] Ziskin, Coping With Psychiatric and Psychological Testimony 181 (2nd ed. 1975), and studies cited therein. *See also* Beck, Ward, Mendelson, Mock & Erbaugh, *Reliability of Psychiatric Diagnosis: A Study of Consistency of Clinical Judgments and Ratings*, 119 Am. J. Psychiat. 351 (1962), cited in Ziskin, *supra*, at 183. "Under relatively optimal conditions, the percentage of agreement among psychiatrists was found to be 54%."

Similarly, the validity, or accuracy, of the psychiatric judgment must be questioned because, when disagreement occurs between two psychiatrists, either one or both must be in error. Therefore, when reliability does not exceed 60 percent, the accuracy of diagnosis cannot exceed 60 percent, and it is probably significantly lower. For a landmark study on the inability of psychiatrists to accurately determine the threshold condition of mental illness, see Rosenhan, *supra* note 14, at 379.

Of all individuals labeled as mentally retarded, the overwhelming majority, approximately 89 percent, fall within the category of mild retardation.[27] Yet "[i]t is also in the mildly retarded range that one finds the largest number of individuals for whom the diagnosis of mental retardation is uncertain."[28] This results from a lack of precision in testing, as well as a cultural bias which exists in the testing.

> A child with an IQ score within the mild range of mental retardation who is from a low-socioeconomic-status group is more likely to be diagnosed mentally retarded than a middle- or upper-class child with a similar score.[29]

Once placed upon a child, the label of mental retardation is usually geared towards his or her potential classroom performance. Yet, the use of the label for that purpose

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[27] National Association for Retarded Citizens, Facts on Mental Retardation 15 (1973).

[28] Hobbs, The Future of Children 52 (1975).

[29] *Id.* at 29-30. In 1968 the President's Committee on Mental Retardation reported that a child in a low income rural or urban family was fifteen times more likely to be diagnosed as mentally retarded than a child from a higher income family. Scheerenberger, *supra* note 19, at 15. *See also Larry P.* v. *Riles,* 343 F. Supp. 1306 (N.D. Cal. 1972), *aff'd,* 502 F.2d 963 (9th Cir. 1974); *Diana* v. *California State Board of Education,* C.A. No. C-70 37 RFD (N.D. Cal. 1970), both concerning culturally biased IQ testing.

> Perhaps there is no other place in the health system where labels are more odious and more invidious. . . . These labels are, of course, applied to a disproportionate number of disadvantaged and minority children. This clinical result is accomplished despite the fact that the tests measure achievement rather than ability and despite the fact that most of those in common use are culture bound instruments.

Stone, *supra* note 22, at 52. *See also* Deutsch, Katz and Jensen, Social Class, Race and Psychological Development 33 n.6 (1968).

may be irrelevant to the individual's ability to function outside the classroom or to his or her need for institutionalization.[30] Frequently, by the time the child completes the process of formal education and becomes integrated into adult working society, he or she is no longer recognized as mentally retarded.[31] Thus, the threshold determination of mental retardation may be extremely misleading in the context of assessing the child's ability to function in the home and in the community.[32]

Amici believe that a hearing is necessary to minimize the risk of error in the commitment of minors to institutions. Such a forum for considering the testimony of various experts, all of whom would be subject to questioning designed to test the accuracy of their findings and recommendations, would guard against wrongful deprivations of liberty.

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[30] *See* Telford and Sawrey, The Exceptional Individual 159 (1967). "Follow-up studies of mildly mentally retarded children show that test scores, by themselves, are poor prognosticators of adult occupational and social adjustment." *See also* Allen, Legal Rights of the Disabled and Disadvantaged 13 (1969). "Unfortunately, legal status is too often determined on the basis of a single I.Q. score despite the reservations expressed by all who participate in the classification process." *See generally* Linn and Bowers, *Analysing the Legal Prohibitions Against Marriages Involving Mentally Retarded Persons—The Eternal Child Grows Up.* 13 Gonz. L. Rev. 625, 652-55 (1978), discussing the complications of the concept of mental retardation and the limitations on the use of I.Q. scores.

[31] *See e.g.,* Mercer, *The Myth of 3% Prevalence* in Sociobehavioral Studies in Mental Retardation 11 (Tarjan, Eyman & Meyers, eds. 1973). *See also* Kay, Farnham, Karren, Knakal and Diamond, *Legal Planning for the Mentally Retarded: The California Experience,* 60 Cal. L. Rev. 438, 441-42 (1972).

[32] Hobbs, *supra* note 29, at 30 and 52. *See also* President's Committee on Mental Retardation, The Six Hour Retarded Child (1976).

2. The Decision to Commit Is Based Upon an Analysis of Factual Information, and Exclusive Reliance Upon Expert Determinations Is Improper. Even if experts in psychiatry and psychology could diagnose mental disability with more accuracy, the need for a hearing would continue to exist. The decision to institutionalize a child is one of much gravity which requires factual findings beyond the threshold establishment of the existence of mental disability.[33] The rationale for civil commitment must also rest upon behavior of the child which evidences a need for treatment or habilitation in an institutional setting. It is the need to test the accuracy of the facts upon which civil commitment is recommended that demands the provision of a hearing; no other procedural mechanism can adequately serve this fact-finding purpose.

In *Goss* v. *Lopez,* 419 U.S. 565 (1975), the Court scrutinized the nature of the inquiries which must be made to accurately determine the facts concerning the behavior of a student. In reviewing the process by which a student could be suspended for disciplinary reasons for a period up to ten days, the Court correctly observed that

> the concern would be mostly academic if the disciplinary process were a totally accurate, unerring process, never mistaken and never unfair. Unfortunately, that is not the case, and no one suggests that it is. Disciplinarians, although proceeding in utmost good faith, frequently act on the reports and advice of others; and the controlling facts and the nature of the conduct under challenge are often disputed. The risk of error is not at all trivial, and it should be guarded against . . . .

Id. at 579-80.

[33] *Cf. O'Connor* v. *Donaldson,* 422 U.S. 563 (1975).

The Court went on to hold that due process requires notice and, for short suspensions not exceeding ten days, an informal hearing. This hearing provides the student with the opportunity to learn of the adverse action being proposed by the school officials and of the reasons why it is being proposed. This hearing also affords the student the opportunity to respond to and attempt to rebut the factual allegations made by school officials.[34]

In *Goss,* the Court also noted that school suspensions for more than ten days or expulsions "may require more formal procedures." *Id.* at 584. *Amici* submit that the Court's recognition of the need for an informal hearing in *Goss,* and the Court's suggestion of the possibility of more formal hearing procedures being required where the educational deprivation is greater, set the framework for this Court's determination in the case at Bar. In the commitment process, where numerous constitutionally protected interests are implicated, due process requires some form of hearing in order to insure the fairness of the fact-finding function.

Justice Powell, in his dissenting opinion in *Goss,* was concerned about the implications of requiring due process protections in "routine school decisions" about student suspensions, which he viewed as similar to numerous decisions left to the expertise of teachers, such as academic evaluations. However, in *Board of Curators of University of Missouri* v. *Horowitz,* ..... U.S. ....., 98 S. Ct. 948 (1978),

[34] The child who is subject to civil commitment frequently experiences a substantial disruption of his or her educational process as a result of institutionalization. *Amici* argue that, as a result of commitment, minors can experience a deprivation of public education benefits that is greater than a ten day suspension, and that a more formalized hearing than that ordered in *Goss* is constitutionally required.

the Court upheld the dismissal of a student from medical school, clarifying the distinction between a student's failure to meet academic standards and a student's violation of rules of conduct. In *Horowitz*, the decision to dismiss the student was based upon "the academic judgment of school officials"—which properly included subjective considerations and evaluative determinations. However, the informal hearing required in *Goss* resulted from the need for an objective determination of the actual conduct of an individual.

Amici argue that a minor's due process right to a hearing in the civil commitment process should be considered in the context of *Goss* and *Horowitz*. Civil commitment results from behavior which must be factually determined, such as behavior which illustrates an inability to function in the community or dangerous acts. While a student can fail a course of study based upon an academic assessment which is not subject to the due process requirement of a hearing, a child cannot be committed merely because a parent or physician diagnoses mental illness or mental retardation. Rather, the label of mental deficiency must be linked to conduct which can be factually proven and which justifies placing the child in an institution.

If the hearings ordered by the lower court in the case at Bar are not approved by this Court, an unacceptable dichotomy will result. A child who exhibits acts or deficiencies of behavior, but who is not mentally disabled, cannot be institutionalized unless such behavior can be controlled through the state's juvenile justice system. In that event, the youth is afforded full due process protections. *In re Gault, supra. See also In re Winship, supra.*

Amici also argue that a child who has been diagnosed as mentally retarded or mentally ill, but who does not ex-

hibit such behavior, cannot be institutionalized upon a mere showing of mental deficiency.[35] Only when mental deficiency exists concurrently with facts concerning the individuals conduct which support a need for institutionalization can commitment occur. These facts are frequently in dispute, and the evidence is often unreliable. Therefore *amici* submit that due process requires a hearing in order to protect against the risk of improper commitment.

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[35] *Cf. O'Connor* v. *Donaldson*, 422 U.S. 563 (1975); *Jackson* v. *Indiana*, 406 U.S. 715 (1972). A factual determination is necessary regardless of whether a parens patriae or a police power rationale is utilized to justify civil commitments. Under the parens patriae doctrine, the commitment standard is often phrased in terms of the "need for care and treatment." This standard demands factual findings concerning the individual's behavior—i.e., suicide attempts, self-injurious behavior, inability to perform the basic tasks of life. The statistical showing that no more than three percent of the total population of mentally retarded persons in the United States has ever been institutionalized illustrates the importance of reviewing an individual's behavior. Scheerenberger, *supra* note 29, at 17.

Additionally, the numerous courts which have rejected the parens patriae rationale have required a factual finding in commitments brought pursuant to the police power—i.e., dangerous behavior based upon overt acts. *E.g. Suzuki* v. *Alba*, 438 F. Supp. 1106 (D. Haw. 1977); *Goldy* v. *Beal*, 429 F. Supp. 640 (M.D. Pa. 1976); *Stamus* v. *Leonhardt*, 414 F. Supp. 439 (S.D. Ia. 1976); *Doremus* v. *Farrell*, 407 F. Supp. 509 (D. Neb. 1975); *Lynch* v. *Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Bell* v. *Wayne County Hospital*, 384 F. Supp. 1085 (E.D. Mich. 1974); *Lessard* v. *Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *remanded*, 414 U.S. 473 (1974), *reinstated*, 379 F. Supp. 1376 (E.D. Wis. 1974), *remanded*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976). *See also Minnesota ex rel. Pearson* v. *Probate Court*, 309 U.S. 270 (1940).

3. Hearings Can Overcome the Exclusive Reliance Upon Institutional Solutions in Commitment Proceedings By Causing an Exploration of Less Restrictive Alternatives Which May Be More Appropriate to the Needs of a Mentally Disabled Child. In many instances parents and even physicians whom they consult have no knowledge of alternatives for residential placement other than the home or an institution. Even the most concerned and well-intentioned parent(s), who feel their child needs services, may be aware of only the highly visible and well-publicized institution which serves their community.

Numerous courts have held that due process requires the application of the least restrictive alternative principle to persons confined in[36] or facing commitment to[37] facilities for the mentally disabled. The constitutional basis for the least restrictive alternative is not at issue here and need

[36] *E.g., Halderman* v. *Pennhurst State School and Hospital,* 446 F. Supp. 1295 (E.D. Pa. 1977); *J.L. and J.R.* v. *Parham,* 412 F. Supp. 112 (M.D. Ga. 1976), *prob. juris. noted,* 431 U.S. 936 (1977), *reargument ordered,* ..... U.S. ....., 98 S. Ct. 761 (1978); *Dixon* v. *Weinberger,* 405 F. Supp. 974 (D.D.C. 1975); *Welsch* v. *Likins,* 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part, remanded in part,* 550 F.2d 1122 (8th Cir. 1977); *New York State Association for Retarded Children* v. *Rockefeller (Carey),* 357 F. Supp. 752 (E.D.N.Y. 1973) and 393 F. Supp. 715 (E.D.N.Y. 1975); *Wyatt* v. *Stickney,* 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom., Wyatt* v. *Aderholt,* 503 F.2d 1305 (5th Cir. 1974).

[37] *E.g., Stamus* v. *Leonhardt,* 414 F. Supp. 439 (S.D. Ia. 1976); *Suzuki* v. *Quisenberry,* 411 F. Supp. 1113 (D. Haw. 1976); *Lynch* v. *Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard* v. *Schmidt,* 349 F. Supp. 1078 (E.D. Wis. 1972), *remanded,* 414 U.S. 473 (1974), *reinstated,* 379 F. Supp. 1376 (E.D. Wis. 1974), *remanded,* 421 U.S. 957 (1975), *reinstated,* 413 F. Supp. 1318 (E.D. Wis. 1976); *Dixon* v. *Attorney General of Commonwealth of Pa.,* 325 F. Supp. 966 (M.D. Pa. 1971). *See also O'Connor* v. *Donaldson,* 422 U.S. 563, 575 (1975), citing favorably *Shelton* v. *Tucker,* 364 U.S. 479 (1960).

not be decided by the Court. However, the focus of the doctrine, whether constitutionally required or not, serves to illustrate that, unless the available alternatives are explored, a minor may be improperly placed in an institution when more appropriate and more beneficial services are available in the community but have been overlooked.[38]

In recent years, the federal government has also pursued the goal of providing services to mentally disabled persons in community settings whenever possible, rather than relying upon institutional care.[39] As a result, community

[38] *See generally* Soskin, *The Least Restrictive Alternative: In Principle and in Application,* Amicus, Vol. 2, No. 6, at 28 (Nov. 1977); Chambers, *supra* note 2.

[39] The federal policy favoring deinstitutionalization can be traced to the Mental Health Study Act of 1955, ch. 417, § 3, 69 Stat. 382, which resulted in a Report of the Joint Commission on Mental Illness and Health entitled "Action for Mental Health," which was submitted to Congress in 1960. Following a one year study, a report of the President's Panel on Mental Retardation entitled "A Proposed Program for National Action to Combat Mental Retardation" was submitted to President Kennedy in 1962. The President then prepared the first special message to Congress on mental illness and mental retardation in 1963, focusing his concerns upon the need for augmenting community services and reducing the population of mental hospitals. Similarly, President Nixon issued a statement in 1971 establishing a national goal of returning a substantial number of mentally retarded persons to the community.

For a discussion of these developments and the numerous federal policies and programs aimed at deinstitutionalization, see Comptroller General of the United States, Report to the Congress—Returning the Mentally Disabled to the Community: Government Needs to Do More (1977). Federal acts and programs designed to implement the deinstitutionalization goal include: the Community Mental Health Centers Construction Act of 1963 and the Community Mental Health Centers Amendments of 1975, 42 U.S.C. § 2689; the Special

(footnote continued)

residences and support services have proliferated.[40] Community-based services have also been determined to be generally the most appropriate approach to the care and treatment of mentally disabled persons by the state.[41]

The formal structure under which the alternatives to commitment are explored can vary in its approach; the underlying importance of the hearing, in its several possible forms, is that the best interests of the child are explored by the inquiry into alternatives. One model would require the state to explore all available alternatives prior to institutional commitment and to present its findings during

(footnote continued)
Health Revenue Sharing Act of 1975, 42 U.S.C. § 246; the Housing and Community Development Act of 1974, 42 U.S.C. § 1437(2); Title XX of the Social Security Act, 42 U.S.C. § 1397; the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6010; and, the Rehabilitation Act of 1973, 29 U.S.C. § 701 et seq.

[40] *See generally* Comptroller General Report, *supra* note 39; Menolascino, Challenges in Mental Retardation (1977); President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded (Kugel and Shearer, eds. 1976); National Association for Retarded Citizens, National Forum on Residential Services (1976).

[41] The State of Pennsylvania has acknowledged and established priorities within its Office of Mental Retardation which heavily emphasize the need to provide services in community-based, noninstitutional settings. *See* Knowlton, *Group Homes,* in National Association for Retarded Citizens, National Forum on Residential Services 117 (1976). The author, who is the director of the Bureau of Community-Residential Services of the Pennsylvania Department of Public Welfare, outlines as "Priority I" support services necessary to keep a child at home, as "Priority II" adoptive and foster homes for children, and as "Priority III" community living arrangements. Institutions are the very last alternative listed and institutional confinement would only be used after a full exploration of all the other alternatives.

the hearing.[42] In the event that the state finds no suitable alternatives, it carries the burden of showing why the alternatives are not suitable. A second model would provide the resources necessary to explore alternatives directly to the hearing system. This could be accompiished either by establishing specific staff positions[43] or by the use of the services of a separate agency.[44]

Amici believe that the commitment of children to institutions without a thorough exploration of other alternatives

[42] *See e.g. Lessard* v. *Schmidt,* 349 F. Supp. 1078 (E.D. Wis. 1972), *remanded,* 414 U.S. 473 (1974), *reinstated,* 379 F. Supp. 1376 (E.D. Wis. 1974), *remanded,* 421 U.S. 957 (1975), *reinstated,* 413 F. Supp. 1318 (E.D. Wis. 1976). The state's investigation could be carried out by the social services staff of the institution or by the staff of local community mental health and mental retardation centers. *See generally* Chambers, *supra* note 2, at 1173-74. This approach also has the advantage of possibly removing the need to institute commitment procedures when mutually agreeable community services are found—perhaps even enabling the child to remain in his natural home because of the provision of support services in the community. *See Developments in the Law, supra* note 12, at 1250-51 n.265.

[43] This model parallels many juvenile court systems where judges rely on the advice received from their own probation staff. It is also similar to the practices of a number of criminal courts. This model has a positive effect of tying the power and prestige of the judge's office directly with the search for alternatives and may lead to the court's eventual involvement in the development of new alternatives. *See* Chambers, *supra* note 2, at 1173.

[44] In several states, advocacy groups, appointed to represent individuals at civil commitment hearings, employ social workers to assist in the exploration of alternative community services. Two such systems are the New York Mental Health Information Service and the Public Defender Service for the District of Columbia at St. Elizabeth's Hospital. *See* Chambers, *supra* note 2, at 1175-76. *See also* Stone, *supra* note 22, at 242.

would create a high probability of inappropriate commitments. Requiring hearings in the commitment process is a sensible approach to insuring that the needs of mentally disabled children are appropriately met.

C. The State's Parens Patriae Interests Substantially Coincide with the Individual's Liberty Interests, and the State's Interests in Economy and in Preserving the Family Unit Are Minimal; Thus, Balancing All of the Interests Affected By Civil Commitment Requires the Provision of Hearings.

The state's primary interest in children arises from its parens patriae power, which is exercised to ensure that the "best interests" of the child are protected. The Court has recognized that children are protected by the Constitution, *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976), and specifically by the fourteenth amendment and the Bill of Rights.[45] *In re Gault*, 387 U.S. 1 (1967). However, the state can limit the rights of children in certain instances through the exercise of its parens patriae authority.[46] *Prince* v. *Massachusetts*, 321 U.S. 158 (1944).

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[45] *See also Carey* v. *Population Services International*, 431 U.S. 678, 692 n.14 (1977), and cases cited therein.

[46] For a discussion of the special state interests which permit limitations on the freedom of minors, see Teitelbaum and Ellis, *supra* note 14, at 7-11. The reasons for these special interests include: the vulnerability of minors to harm; their lack of mature judgment; and, the maintenance of family authority. Thus, permissible state intervention can include: restricting dangerous religious activities of children; mandating school attendance; limiting access to objectionable or obscene materials; prohibiting child labor; and, restricting the use of alcohol. *Id.* at 6-8.

The Court has recognized, however, that the state's exercise of its parens patriae authority "is not an invitation to procedural arbitrariness." *Kent* v. *United States*, 383 U.S. 541, 555 (1966).

Similarly, when the state's intervention promotes the "best interests" of the child, the state can limit the control which parent(s) exercise over their child in certain circumstances.[47]

Amici believe that the state's interest as parens patriae substantially coincides with the private liberty interests of the child in the civil commitment process. Certainly, the child's interest in liberty in its most basic sense—the desire to be free from restrictions on bodily movement and from the harms of institutionalization, the avoidance of unnecessary lifelong stigma, and the need to grow and be nurtured in a setting which approximates as closely as possible a natural family situation—are also governmental interests. Similarly, there exists a strong state interest in avoiding inappropriate commitments of children to institutions when

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[47] In upholding a restriction on children selling religious literature on the streets, the Court observed that

> Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.

Prince v. *Massachusetts*, 321 U.S. 158, 170 (1944). Under this rationale, the state may limit parental control, for instance, through child deprivation, neglect or abuse proceedings.

Recently this principle has been reiterated by the Court.

> To be sure, the power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens.

Wisconsin v. *Yoder*, 406 U.S. 205, 233-34 (1972).

the child's best interests are more adequately served by alternative means.[48]

Amici submit that the parens patriae interests of the state actually militate in favor of the provision of due process hearings. Although the state may assert other interests which are not supportive of the provision of such hearings, such as the potential of harm to the family unit and the possibility of increased costs to the state, *amici* argue that these interests fall far short of overriding the various interests at issue which favor requiring hearings.

1. The Provision of Hearings Will Not Interfere with the State's Interest in the Maintenance of the Family Because the Parental Decision to Seek the Commitment of a Child to an Institution Has Already Weakened the Family Unit. The state has a strong interest in upholding the sanctity of the family and in maintaining parental control over the rearing of children. *Smith* v. *Organization of Foster Families for Equality and Reform*, 431 U.S. 816 (1977); *Moore* v. *City of East Cleveland, Ohio*, 431 U.S. 494 (1977); *Wisconsin* v. *Yoder*, 406 U.S. 205 (1972); *Stanley* v. *Illinois*, 405 U.S. 645 (1972); *Meyer* v. *Nebraska*, 262 U.S. 390 (1923). However, *amici* argue that once the

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[48] The hearing process is an effective way to quickly screen out individuals who should not be committed, without frustrating the state's ultimate goals in commitment. *Developments in the Law*, *supra* note 12, at 1278. The state's ultimate goal, however, is the child's best interests. *Amici* submit that the hearing process best pursues this goal by insuring that alternatives to commitment are explored.

> The concept of community based resources with the mentally disabled individual being retained in his home as much and as long as possible is the most appropriate social policy if we are to consider the child's best interest.

Stone, *supra* note 22, at 124.

parent(s) have sought the commitment of their child to an institution, the governmental interest in maintaining that particular family unit has already been severely weakened by the parental actions, and the state's interest in preserving familial relationships is thereby reduced.

In *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976), the Court rejected the state's claim that an unmarried minor must obtain parental consent prior to aborting her pregnancy.[49] The Court recognized that

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[49] In his concurring opinion, Justice Stewart noted that

> a materially different constitutional issue would be presented under a provision requiring parental consent or consultation in most cases but providing for prompt . . . judicial resolution of any disagreement between the parent and the minor. . . .

Id. at 90-91 (Stewart J., concurring). Thus, an absolute power in parent(s) to control the fundamental right of their child to seek abortion is unacceptable, yet a statute providing the parent with power to control the child's rights, subject to judicial review, might be acceptable. Similarly, in *Belloti* v. *Baird*, 428 U.S. 132 (1976), the Court abstained from deciding the constitutionality of a state statute governing the abortion of a minor.

> The picture thus painted by the respective appellants is of a statute that prefers parental consultation and consent, but that permits a mature minor capable of giving informed consent to obtain, without undue burden, an order permitting the abortion without parental consultation, and, further, permits even a minor incapable of giving informed consent to obtain an order without parental consultation where there is a showing that the abortion would be in her best interests. The statute, as thus read, would be fundamentally different from a statute that creates a "parental veto."

Id. at 145.

This approach is consistent with the Court's decision in *Wisconsin* v. *Yoder*, 406 U.S. 205 (1972). There, the Court distinguished the situation where parent(s) were preventing their children from attending school against the children's expressed desires to attend and did not address that issue in the decision. *Id.* at 231.

placing such authority in the hands of a parent would not accomplish the state's objective of safeguarding the family unit and parental authority because, when the parent(s) and child disagree over such a fundamental right affecting the child, the family structure has already been fractured.[50] *Id.* at 75.

In *Smith* v. *Organization of Foster Families for Equality and Reform*, 431 U.S. 816 (1977), the Court considered the right of a minor to a judicial hearing prior to being removed from a temporary foster home placement (of more than eighteen months duration) and returned to his or her natural family. The district court held that it was in the child's interest to have an automatic hearing, because the child might be unable to request a hearing on his or her own and because the foster parents, acting in their own interests, might not request a hearing. The Court, in reversing this decision, recognized the state's interest in maintaining family privacy and autonomy. The Court reasoned that, when the foster parents do not request a hearing on behalf of the child,

> it is difficult to see what right or interest of the foster child is protected by holding a hearing to determine whether removal would unduly impair his emotional attachments to a foster parent who does not care enough about the child to contest the removal.

Id. at 850. *Amici* assert that the Court's refusal to require hearings to protect the child's liberty interest in maintaining a familial relationship within the foster home, under the rationale that the relationship has been severely weakened by the acquiescence of the foster parents to the

[50] "At least in cases involving fundamental rights, there must be some showing that denial of the child's liberty *will* strengthen the family unit; a bare allegation to that effect will not suffice." Teitelbaum and Ellis, *supra* note 14, at 12 (emphasis in original).

removal of the child, lays a foundation from which to consider the case at Bar.

In pursuing the commitment of their minor child, the natural parent(s)' actions seriously undermine the claim that the right of family autonomy should outweigh the child's fundamental rights which are affected by commitment.[51] As in *Danforth, supra,* the family structure may already be fractured.

When the issue addressed concerns the placement of the child in either his or her natural home or in a foster home, where the surrogate parent(s) have chosen not to exercise their right to request a hearing in which they seek to retain custody of the child, no hearing on the child's behalf is required. However, when the alternative the natural parent(s) are seeking is to relinquish their child to an institution, the best interests of the child are much more difficult to ascertain.[52] Thus, mandating hearings will best serve the state's interest in protecting the best interests

[51] For a thorough analysis of the child's liberty interest and potentially conflicting parental interests which concludes that, once the family reaches outside the home to treat the problem, the liberty interest takes precedence. see Teitelbaum and Ellis, *supra* note 14, at 14-22.

[52] Much evidence exists to indicate that a child's interests are not served by removal from a family situation and placement in an institution.

> Infants and children placed in institutions instead of being wanted in their own family, an adoptive or foster family, have an obvious disadvantage. Whatever beneficial qualities a psychological parent may be lacking, he offers the child the chance to become a wanted and needed member within a family structure; ordinarily this cannot happen even in the institutions where

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of the child without interfering with the potentially competing interest of the state in maintaining the family.[53]

2. The State's Interest in Governmental Economy Is Illusory Because the Incremental Cost of Providing Automatic Hearings Will Be Marginal. The court below acknowledged in its decision that all of the due process procedures outlined would not be required in every case, and the court held that all of the child's rights could be waived except for notice and counsel (or trained advocate). It was thus assumed by the lower court that not every child would, in fact, receive a hearing.

On the other hand, the state legislative framework already provides for the provision of a substantial number of hearings. Each person, whether alleged to be mentally ill

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care, safety, and stimulation may be provided, but where the individual child has no psychological parents.

Goldstein, Freud and Solnit, *supra* note 20, at 21. The Project on Classification of Exceptional Children, a study undertaken at the request of then Secretary of Health, Education, and Welfare Elliott Richardson, reached the conclusion that "the large, congregate residential institutions for children of all categories . . . should be closed and the children cared for in community-based programs." Hobbs, *supra* note 28, at 253. *See also,* Scheerenberger, *supra* note 19, at 19-39. *See generally* Joint Commission on Mental Health of Children, Crisis in Child Mental Health: Challenge for the 1970's (1969) (a report to Congress mandated by the Social Security Amendments of 1965 and 1968).

[53] The Court recently had before it another case in which a minor's fundamental interest—the right to procreate—was abridged by the actions of a parent in conjunction with physicians and a state court judge. *Stump* v. *Sparkman,* ..... U.S. ....., 98 S. Ct. 1099 (1978). While the case turned on the issue of judicial immunity, the facts illustrate the potential conflict between the parent(s) and the child. A judicial hearing, in which the child is afforded due process protections, would undoubtedly serve the best interests of the child, without further damage to the government's interest in family autonomy.

or mentally retarded, for whom application has been made for "involuntary" commitment, must be provided with a hearing. The provision of these hearings will not be affected by the decision of this Court. In addition, each allegedly mentally ill child under the age of fourteen receives a hearing if any responsible party files a petition for his or her release. Each mentally retarded child between the ages of thirteen and eighteen receives a hearing if he or she objects to institutionalization or notifies an attorney who subsequently requests discharge. Under the present legislative scheme, all children except those mentally retarded children below the age of thirteen could potentially have hearings.[54] Therefore, the theoretical prospect of a significant additional fiscal or administrative burden on the state may not be substantial.

Even assuming a significant increase in the number of hearings, the overall costs to the state will be minimized, if not transformed into savings, by the reduction in the number of children erroneously committed to institutions.[55]

[54] Of course, *amici* acknowledge that the existing commitment scheme is challenged in the case at Bar because of the heavy burden placed upon the child or "interested" third parties to obtain access to a hearing which *amici* argue should be constitutionally mandated.

[55] For a discussion of the benefits and cost reductions of providing community education and training services and of reducing the institutional population, which shows that community care is less expensive than institutional care and which outlines the increased societal productivity which results from deinstitutionalization, see Conley, The Economics of Mental Retardation (1973).

Pennsylvania is already under a court order to develop community services for all the mentally retarded residents of one of its institutions, as a result of the court's finding that residents should not be confined at Pennhurst State School and Hospital. *Halderman* v. *Pennhurst State School and Hospital,* 446 F. Supp. 1295 (E.D. Pa. 1977).

Since nearly all mentally retarded persons who are institutionalized are committed as minors and because the median period of institutionalization is nearly fifteen years,[56] the fiscal effect of reducing erroneous commitments can be staggering.[57]

III.

THE STATE SYSTEM GOVERNING THE COMMITMENT OF MINORS DOES NOT SUFFICE AS A SUBSTITUTE FOR REQUIRING HEARINGS AND FRUSTRATES THE GOAL OF PURSUING THE BEST INTERESTS OF HANDICAPPED CHILDREN.

A. Neither the Denial of Access to a Hearing Nor the Placement of the Burden of Affirmatively Exercising the Right to Request a Hearing Upon the Child or an Undetermined "Responsible Party" Provides Sufficient Protections for the Minor's Interests.

Under the state commitment system which is being scrutinized in the case at Bar, mentally retarded children under the age of thirteen are afforded absolutely no opportunity for a hearing in which to challenge their commitment.

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[56] Cohen, *Advocacy*, in The Mentally Retarded Citizen and the Law 591, 599 (Kindred, ed. 1976), citing Department of Health, Education and Welfare, Mental Retardation Source Book 39, 47 (1972).

[57] Regardless of the cost factor in providing hearings, *amici* assert that the weight which this governmental interest is afforded should be minimal. Clearly, the increasing costs of criminal prosecutions cannot justify any significant relaxation of the constitutional rights of criminal defendants. Likewise, the liberty interest of the child and the concern for insuring that the child's best interests are served are of more import than the state's fiscal concerns.

Mentally retarded children who are thirteen or older receive notification of their rights and the telephone number of an attorney who can be called for representation. If the child objects to commitment, an involuntary commitment can be initiated which contemplates the provision of a hearing. Mentally ill children under the age of fourteen may only be withdrawn from the institution by their parent(s) or guardian(s); however, a "responsible party," acting in the child's best interests, may petition for a hearing on the child's behalf.

Focusing first upon mentally retarded children, *amici* argue that these provisions do little to safeguard the child's interests, and they do not constitute an adequate alternative to a mandatory due process hearing. *Amici* ask this Court to recognize that these mentally retarded children have a double disability: minority and handicapping condition. Upon being removed from his or her home, family and friends and placed in a strange institutional atmosphere, the child is likely to be extremely confused. Children in such a situation may find it very difficult to muster the initiative to contact an attorney or to object to the commitment and demand a hearing, especially when they may perceive such action as a challenge to their parent(s).

Additionally, the child's mental retardation further decreases the likelihood that the state's procedures will be invoked. By definition, mentally retarded persons suffer from an impairment in intellectual ability. Depending on the severity of retardation, the child may not even have the ability to comprehend the available procedures. If the child cannot speak or advocate on his or her own behalf, the availability of these procedures becomes mean-

ingless.[58] The child's functional or instinctive opposition to institutionalization will go unheeded, unless he or she has the intellectual ability to formulate a protest or to take action.

Similarly, the state's procedures for mentally ill children lack appropriate safeguards. Unless a "responsible party" wishes to initiate a hearing on behalf of the child, the child never receives the benefit of a review of the commitment. Along with mentally retarded children under the age of thirteen who never receive a hearing, mentally ill children under the age of fourteen are deprived of the right to hearings which would be especially beneficial to younger children. Since younger children are more helpless, more vulnerable to arbitrary and erroneous actions, and more likely to suffer irreparable harm, through loss of parental ties, deprivation of education, and lifelong stigmatization, during their prime periods of development,

[58] Even if a mentally retarded child has the ability to advocate on his or her own behalf, the child may be constrained from exercising that option. According to the report of the Task Force on Law of the President's Panel on Mental Retardation,

> [t]he retarded are particularly vulnerable to an atmosphere of threats or coercion, as well as to one of friendliness designed to induce confidence and cooperation. The retarded person may be hard put to distinguish between the fact and the appearance of friendliness. . . . Some of the retarded are characterized by a desire to please authority. . . .

Bazelon, Boggs, Hilleboe, and Tudor, Report of the Task Force on Law: The President's Panel on Mental Retardation (1963), cited in Menolascino, *supra* note 40, at 185. Menolascino further notes that, especially in situations filled with anxiety, "[o]ften the retarded individual does not fully comprehend his situation, nor, because of his intellectual deficit, can he handle his frustration." *Id.* at 186. *See also* Person, *The Accused Retardate*, 4 Col. Hum. Rts. L. Rev. 239, 254 (1972).

hearings are necessary to ensure that their best interests are protected.[59]

The state recognizes that adults and mentally ill children who are over fourteen years of age can choose whether to be voluntarily institutionalized; if they do not consent to commitment, they can only be institutionalized after a mandatory hearing. Yet, all mentally retarded children and younger mentally ill children, who would benefit most from having a mandatory due process hearing, are afforded no such right. As to these children, the state has either created obstacles which realistically minimize the opportunity for a hearing, or the state has unilaterally denied the individual's access to the protections of the hearing. *Amici* believe that these arbitrarily drawn statutory lines are to the detriment of mentally disabled children.

[59] Dr. Eli Messenger, in testifying before the lower court in its first consideration of this matter, *Bartley* v. *Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded*, 431 U.S. 119 (1977), stated:

> I think in fact that the need for a hearing in the younger children is greater, because one cannot fully expect them to understand fully, certainly in legal terms, their dilemna, nor can they be aware of alternate forms of therapy. . . . I think that because younger children are less sophisticated and less knowledgeable, that we have to bend over backwards to protect their rights.

Appendix at 631a, cited in *Institutionalized Juveniles* v. *Secretary of Public Welfare*, No. 72-2272, slip op. at 35 (E.D. Pa. May 25, 1978), *prob. juris. noted*, ... U.S. ....., 98 S. Ct. 3087 (1978). Similarly, Dr. Henry Kandler, an expert who also testified at the first trial, has indicated: "I also believe that there should be no lower age limit—children younger than 13 need more protection, if anything, since they are more helpless." National Juvenile Law Center, Legal Challenge to the "Voluntary" Admission of Children to Mental Institutions, Vol. II, at 276 (1976). *See also* Teitelbaum and Ellis, *supra*, note 14, at 34-35.

B. The Safeguards Claimed by the State in Requiring a Referral from a Professional and a Review by the Director of the Institution Do Not Constitute an Adequate Substitute for a Due Process Hearing.

Under the state system, a mentally retarded child may be admitted to an institution upon the referral of a pediatrician, general physician or psychologist. *Amici* submit that such professionals generally play a significant role in influencing the parent(s)' decision to institutionalize their child, either by suggesting and encouraging the commitment or by supporting the parent(s)' initial decision to commit.[60] Yet, there is much evidence to indicate that the opinions of these professionals are frequently not based upon an expertise of mental retardation, nor are they always made with the child's best interest in mind.

Summarizing the recent philosophy in this area, Dr. Frank Menolascino, a nationally recognized expert in the field of mental retardation and past president of the National Association for Retarded Citizens, states: "It was thus common in the not too distant past for professionals to advise parents to remove a mentally retarded child from

[60] *See e.g.*, Downey's study in 1965 which concluded that "a physician's recommendations were a major influence among all parents [in their decision to commit their child]." Scheerenberger, *supra* note 19, at 134. A California study of family decisions to institutionalize children found that professionals, especially medical doctors, almost uniformly advised placement in an institution, and "[a]ll but five of the 83 families who had admitted their children to state hospitals or had applied for admission did so upon professional advice." Kay, Farnham, Karren, Knakal and Diamond, *supra* note 31, at 486. *See also* Teitelbaum and Ellis, *supra* note 14, at 44-47.

the hospital or home and to sever all emotional ties with the retarded family member." [61]

The bias towards institutionalization and the lack of information about the current developments in the area of mental retardation cut across all areas of specialty. Parents of mentally retarded children will encounter this prolem in their initial contacts with obstetricians [62] and pediatricians.[63] Later, contacts with general physicians [64]

[61] Menolascino, *supra* note 40, at 92.

[62] [W]e concluded that there is a growing trend favoring home care of every young child whenever possible. However, many including most of the obstetricians interviewed (who have perhaps least contact with retarded children, but whose opinion may weigh most heavily with parents at that traumatic time of first discovery of an apparent impairment)—still urge institutionalization of retarded children under 6, even in the face of parental objection (especially in the case of the mongoloid child, whom they view with despairing negativism). In fact, a majority of obstetricians said they would recommend institutionalization of *all* infants recognized as retarded where there are other children in the home.

Allen, *supra* note 30, at 13-14 (emphasis in original).

[63] [T]hough pediatrics has recently taken an active role in mental retardation (via the university-affiliated mental retardation centers), there are relatively few developmentally oriented pediatricians who are strongly identified with the field of mental retardation.

Menolascino, *supra* note 40, at 60-61.

[64] A recent study illustrates that, although the family doctors may be the primary source of information and care, they may not be knowledgeable about alternatives to institutionalization, nor about the advisability of investigating such alternatives.

The study found that a large number of pediatricians and gen-

(footnote continued)

or psychiatrists [65] will not alter this woeful situation.

Thus, the referral which accompanies the child to the institution cannot be perceived as an effective safeguard against erroneous commitment which eliminates the need for a due process hearing. Likewise, a review by the institutional director will not be a sufficient substitute for a hearing. Such reviews commonly consist of an admission interview, which is performed by a staff psychiatrist or physician.

Whether the child is mentally ill or mentally retarded, he or she faces a situation which is heavily weighted towards the overprediction of illness or disability, and in which the physician may perceive that there is little choice but to authorize commitment.[66] Physicians are taught and

(footnote continued)

> eral practitioners were unfamiliar with the local services for the retarded. In addition, 80% of the physicians were still recommending institutionalization for some of their patients who are severely or profoundly retarded, and 54% are making such recommendations for the moderately retarded. If the sample is representative, then it would appear that many physicians are working at cross purposes with other professionals in the field of mental retardation.

Kelly and Menolascino, *Physicians' Awareness and Attitudes Toward the Retarded,* Mental Retardation, Vol. 13, No. 6, at 13 (Nov./Dec. 1975).

[65] Dr. Menolascino, himself a psychiatrist, indicates that it is common to find a

> lack of knowledge among psychiatrists concerning therapeutic possibilities and the necessary components of meaningful programs for the retarded. . . . This lack of understanding is stressed because it has probably led directly to the psychiatrist's misdirected defense of the tragic models of care which have recently been so clearly condemned.

Menolascino, *supra* note 40, at 55-56.

[66] *See* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 Calif. L. Rev. 840, 863-68 (1974).

practice under a medical model which rests upon the principle that "judging a sick person well is more to be avoided than judging a well person sick." [67] When a child is presented to the physician at the institution, the physician will tend to overpredict the need for commitment; by so doing, he or she greatly reduces the professional consequences of an erroneous decision.[68]

In addition, the admitting physician is generally approached by parent(s) who are requesting the admission of their child and who may have a referral from a physician or other professional in the community. The admitting physician faces the alternative of routinely admitting the child or rejecting the referral and telling the parent(s) to return home with the child. There is little opportunity to investigate the factual situation or the home environment, or to explore the possible alternatives to commitment. The admitting physician is essentially faced with a fait accompli. All the concerns about the appropriateness of the placement which should be raised at the point of admission, and which the institutional director might ideally wish to raise, can only be properly considered in a due process hearing.

[67] Dershowitz, *The Law of Dangerousness: Some Fictions About Predictions,* 23 J. Leg. Educ. 24, 46-47 (1970). *See also* Stone, *supra* note 22, at 49.

> Despite massive empirical evidence that long term confinement is debilitating the view persists among many practitioners that "there is no harm in playing it safe" by recommending commitment when there is the slightest suggestion it may be helpful.

[68] Peterson and Seo, *Bayesian Analysis of Overprediction of Insanity,* 34 Psychol. Rep. 207 (1974). An erroneous decision to commit will probably go unnoticed in that no hearing occurs and, if the child is subsequently released, the physician can take credit for the "improvement" in the child's condition. On the other hand, an erroneous decision not to commit could subject the physician to subsequent exposure if the child's condition worsens or if an incident occurs in the community.

C. The Informal System Created by the State for the Commitment of Minors without Mandatory Due Process Hearings Encourages the Widespread Usage of Institutionalization, Which Is Contrary to the Best Interests of Handicapped Children.

The implications of this Court's decision for all handicapped children will be vast. Historically, the civil commitment process has been conducted informally, with a view toward administrative convenience. However, an increasing number of courts, following the Court's previous pronouncements with regard to the juvenile justice system, are now carefully scrutinizing the commitment process and demanding the application of strict due process procedures.[69]

Mentally ill and mentally retarded children, as well as children with epilepsy, cerebral palsy and other physical handicaps have been traditionally subjected to lifetimes of institutionalization.[70] This Court's decision will indi-

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[69] *Amici* wish to reemphasis that this Court need not decide the full extent of procedural due process protections which must attach to the commitment of minors. The case at Bar presents only the question of whether some form of due process hearings are constitutionally required. Definitions of many of the specific procedural elements of such hearings should be left for future cases. *E.g. State* v. *Addington*, 557 S.W.2d 511 (Tex. 1977), *prob. juris. noted*, ... U.S. ....., 98 S. Ct. 1604 (1978) (No. 77-5992) (appropriate standard of proof in civil commitments); *see generally* discussion, note 1, *supra*.

[70] *See generally* Commission For the Control of Epilepsy and Its Consequences, The Plan For Nationwide Action on Epilepsy (1977) (on epilepsy); Kugel, *Introduction*, in President's Committee on Mental Retardation, Changing Patterns in Residential Services For the Mentally Retarded 3, 5 (Kugel and Shearer, eds. 1976) (on mental retardation, cerebral palsy and other physical disabilities); Blatt, Souls in Extremis: An Anthology on Victims and Victimizers (1973) (on mental retardation).

cate whether the Court encourages a return to the routine institutionalization of handicapped children, or whether instead the Court supports the growing recognition and movement towards the provision of community services to, and the social integration of, handicapped children.

If the Court condones an informal administrative process, it will be encouraging the creation of a "greased runway"[71] leading to the incarceration of handicapped children in institutions. The Court's decision will be a signal to parents as to the degree of concern they must exercise prior to the commitment of their child. Similarly, the Court's ruling will indicate to the state how far it must go in ensuring that appropriate community services and facilities are made available to handicapped children. A lax procedural process will undoubtedly minimize the scrutiny which is given to future civil commitments.[72]

The evidence concerning the loss of fundamental rights, the potential of harm to the individual's development and the lifelong stigma which can result from institutionalization is abundantly clear. Equally evident is the trend toward the protection of the rights and best interests of handicapped children through the focus on community-based services. If the child's best interests are to be served, it can only occur through the establishment of a

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[71] *State ex rel. Memmel* v. *Mundy*, No. 441-417 (Cir. Ct. Wis. August 8, 1976), *appealed on other grounds*, 75 Wis. 2d 276, 249 N.W.2d 573 (1977). This decision vividly describes how informal procedures can result in erroneous commitments and massive deprivations of rights.

[72] *See* Stone, *supra* note 22, at 122. "It seems clear that the only reasonable legal, medical, and ethical policy to follow is one which is directed towards making entry into such large total institutions as difficult as possible."

procedural device to insure against the errors which have occurred in the past—as in numerous other cases decided by the Court, that procedural device is a due process hearing.

CONCLUSION

For the reasons discussed in this brief, *amici* respectfully request this Court to affirm the decision of the United States District Court for the Eastern District of Pennsylvania.

Respectfully submitted,

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FOR ARGUMENT

No. 77-1715

IN THE

Supreme Court of the United States

OCTOBER TERM, 1978

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated,

Appellants,

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees.

On Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania

BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1978

No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated,

Appellants,

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees.

On Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania

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BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

INTEREST OF AMICUS CURIAE

The American Bar Association is a national membership organization of the legal profession. It counts as members more than 220,000 lawyers from all states and the District of Columbia and has, since 1944, maintained an active interest in the field of mental disability law.[1] This interest was intensified in 1973 when the Board of Governors of the American Bar Association established a Commission on the Mentally Disabled, a 17-member interdisciplinary body charged with promoting effective legal assistance to the mentally disabled, and with recommending and implementing programs designed to correct pervasive deficiencies in the nation's mental disability system. Since its inception, the Commission on the Mentally Disabled has focused its efforts toward, *inter alia*: mobilizing, activating, and awarding grants to local and state bar associations to encourage legal representation of the mentally disabled (including appropriate substantive technical assistance); establishing and publishing the *Mental Disability Law Reporter* (hereinafter MDLR), an interdisciplinary journal which reports significant developments in the mental disability law field; operating a model in-house patient advocacy project at three state hospitals in Pennsylvania; and developing model legislation to secure rights and services for mentally retarded and other developmentally disabled persons.

The Commission on the Mentally Disabled has been active in shaping Association policy with respect to the

[1] The Association established a Special Committee on the Rights of the Mentally Ill 34 years ago; this committee's recommendations led ultimately to the publication of a number of path-breaking studies by the American Bar Foundation, created by the Association in 1952. *See* Lindman & McIntyre, *The Mentally Disabled and the Law* (1961); Rock, Jacobson, & Janopaul, *Hospitalization and Discharge of the Mentally Ill* (1968); Matthews, *Mental Disability and the Criminal Law* (1970); Brakel & Rock, *The Mentally Disabled and the Law* (rev. ed. 1971).

mentally disabled. Pursuant to a Commission recommendation, the Association's House of Delegates adopted in August 1978, a policy statement calling for increased procedural protections during the civil commitment process, as recommended by the President's Commission on Mental Health in its *Report to the President* (April 1978).

The Association has also taken the lead in establishing standards for the administration of justice, such as its *Standards for the Administration of Criminal Justice* and its *Standards Relating to Trial Courts* (see part 2B, *infra*). In addition, the Association has recently completed a 23-volume tentative draft of juvenile justice standards. Thus, the Association is uniquely experienced and interested in the question now before the Court.

With due consideration of the extended factual legal analysis offered in the briefs of the parties and other *amici*, the Association, with the written consent of the parties,[2] sets forth its views herein on the important question of whether, and to what extent, the Constitution requires procedural safeguards for minors facing civil commitment on the basis of alleged mental disability.

QUESTION PRESENTED BY AMICUS

Whether the Due Process Clause of the Fourteenth Amendment applies to the nominally voluntary but in fact involuntary civil commitment of juveniles on the basis of alleged mental disability,[3] and, if so, whether due process requires substantially the same procedural protections for such children as it does for adults?

[2] Copies of letters indicating the parties' consent have been filed with the Clerk of the Court.

[3] As used herein, the term "mental disability" includes both mental illness and mental retardation.

STATEMENT OF THE CASE

On November 16, 1972, the plaintiffs in *Bartley* v. *Kremens*, 402 F.Supp. 1039 (E.D. Pa. 1975), who were patients in Pennsylvania's Haverford State Hospital, filed a class action pursuant to 28 U.S.C. §§ 1331 and 1343 (3) and 42 U.S.C. § 1983 in the United States District Court for the Eastern District of Pennsylvania. A three-judge court was sought and convened pursuant to 28 U.S.C. §§ 2281 and 2284. The action was brought against the Director of Haverford State Hospital and officials of the Pennsylvania Department of Public Welfare, on behalf of all mentally ill and mentally retarded children (18 years of age or younger) admitted or committed indefinitely to mental institutions under Sections 402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966, 50 P.S. §§ 4402 and 4403.

The minor plaintiffs alleged that the Pennsylvania statutory procedure constituted a denial of due process and equal protection of the law under the Fourteenth Amendment to the Constitution of the United States. The statutory provisions in question provided that persons 18 years of age or younger may be institutionalized upon the application of a parent, guardian, or person *in loco parentis*; such institutionalization is considered a "voluntary" admission or commitment.[4] The admission/commitment procedure under challenge provided no opportunity for a hearing or assistance of counsel and merely required a finding by the director of the facility upon admission that the child "is in need of care or observation." Subsequent to plaintiffs' initiation of the action, the Secretary of Public Welfare published regulations which

[4] The record in *Bartley* indicates that "voluntary" admissions or commitments are often against the expressed wishes of members of the plaintiff class, and are frequently based upon reasons unrelated to the mental condition of the child involved. 402 F.Supp. at 1044; A. 210-221.

augmented the challenged statutory procedures (3 Pa. Bull. 1840 (1973)), but which did not address the procedural deficiencies claimed by plaintiffs.

On July 24, 1975, the District Court ruled on due process grounds, one judge dissenting, that the voluntary admission and commitment procedures of 50 P.S. §§ 4402 and 4403 were unconstitutional as applied to children 18 years of age or younger. *Bartley* v. *Kremens*, 402 F. Supp. 1039, 1054 (hereinafter cited as *Bartley*). Central to the court's holding was its determination that a "child's interest in not being institutionalized . . . is safeguarded by the Fourteenth Amendment." 402 F.Supp. at 1046-47. The District Court specifically rejected defendants' argument that due process protections should not apply because the state is acting as *parens patriae* and not as an adversary in the admission/commitment of children, and because the admission/commitment proceedings are civil, not criminal, in nature. The court held that such reasoning ignores the fact that the child in question is involuntarily removed from his home and community, the stigma associated with civil commitment, and the possibility of erroneously and wrongfully depriving children of their liberty by committing them to mental institutions without proper fact-finding procedures. 402 F. Supp. at 1045-1047. The court also found, on the basis of facts in the record, that "[i]n deciding to institutionalize their children, parents, as well as guardians *ad litem* or persons standing *in loco parentis*, may at times be acting against the interest of their children," and thus should not be authorized to waive personal constitutional rights of their children. 402 F.Supp. at 1047-48. The District Court also enumerated a range of procedural guarantees which it said must be afforded prior to institutionalization of plaintiff class members on the basis of alleged mental disability.

The defendants appealed the judgment of the District Court to this Court pursuant to 28 U.S.C. § 1253, and

made application for a stay pending appeal. A stay was denied by the trial court but subsequently granted by this Court on December 15, 1975. Probable jurisdiction was noted by this Court on March 22, 1976. On July 9, 1976, the Pennsylvania legislature enacted the Mental Health Procedures Act of 1976, which repealed the provisions of the 1966 Act, leaving only Sections 402 and 403 in effect as they relate to retarded persons. Article II of the 1976 Act specifies the procedures for voluntary inpatient treatment of mentally ill persons. Section 201 of the 1976 Act (50 P.S. § 7201) allows a parent, guardian, or person *in loco parentis* to apply for commitment/admission of a child under age 14. Section 206 (50 P.S. § 7206) provides for withdrawal from voluntary inpatient treatment where the parent, guardian, or person *in loco parentis* applies for the release of the committed person under age 14.

On May 15, 1977, this Court ruled that the 1976 Act mooted the claims of the named plaintiffs, and that the 1976 Act and the 1973 Regulations had "fragmented" the class certified by the lower court. *Kremens* v. *Bartley*, 431 U.S. 119, 134 (1977). The case was vacated and remanded "for consideration of the class definition, exclusion of those whose claims are moot, and substitution of class representatives with live claims." 431 U.S. at 135.

On May 25, 1978, the District Court ruled that the procedures for voluntary commitment of mentally ill and mentally retarded juveniles, as set forth in the 1966 Act, the 1973 Regulations, and the 1976 Act, were unconstitutional on their face and as applied to plaintiffs, and enjoined their enforcement. In so ruling, the court determined that the action could be maintained on behalf of juveniles under 14 years of age committed under Section 201 of the 1976 Act, and on behalf of juveniles 18 years of age or younger committed under Sections 402

and 403 of the 1966 Act. *Institutionalized Juveniles* v. *Secretary of Public Welfare*, Civ. Act. No. 72-2272 (E.D. Pa. May 25, 1978) (hereinafter cited as *Institutionalized Juveniles*).[3]

The *Institutionalized Juveniles* court reaffirmed its conclusions in *Bartley* that plaintiffs had a liberty interest, protectable under the Fourteenth Amendment, in not being institutionalized without due process of law. *Bartley*, 402 F.Supp. at 1046; *Institutionalized Juveniles*, A. 1076a-77a. This liberty interest was found to encompass protection of the juveniles against physical restraint and confinement, as well as protection of the juveniles' reputation, which was found to be implicated because of the stigma attached to institutional commitment. *Institutionalized Juveniles*, A. 1077a. The court further reaffirmed its earlier holding that parents could not waive the constitutional right of their children not to be deprived of liberty without due process of law (*Bartley*, 402 F.Supp. at 1047, *Institutionalized Juveniles*, A. 1078a), citing the "substantial stigma" attached to institutionalization, the "substantial danger of error in the diagnosis of mental illness and mental retardation," the potential for long-term loss of liberty, and the "substantial potential for conflict between the interests of the parent and child." *Institutionalized Juveniles*, A. 1077a-78a.

The *Institutionalized Juveniles* court also affirmed and elaborated on the procedural due process requirements set forth in *Bartley* at 402 F.Supp. 1053. As set forth in *Institutionalized Juveniles*, the following procedures were required to attend the admission/commitment of plaintiff class members on the basis of alleged mental disability:

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[3] For the convenience of the Court, page references to the text of the *Institutionalized Juveniles* opinion will be made to Volume III of the Appendix, which reproduces the opinion at A. 1051a-1115a.

A. [Notice] Prior written notice of the date, time and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney.

B. [Counsel] Counsel or other trained representative during all significant stages of the commitment process; if the juvenile is indigent, counsel or other trained representative shall be provided for free.

C. [Presence of Juvenile and Other Hearing Rights] Presence of the juvenile at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

D. [Standard of Proof] A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

E. [Probable Cause Hearing] A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

F. [Full Commitment Hearing] A full commitment hearing within two (2) weeks from the date of the initial detention. [*Institutionalized Juveniles*, A. 1093a-94a]

As in *Bartley*, 402 F.Supp. 1053 n.26, the *Institutionalized Juveniles* court specified in its opinion and order at A.1079a, n.48, and its implementing order at A. 1094a, 1096a, and at 1098a, that with the exception of notice

and counsel, all of the above listed protections could be waived in appropriate cases by a child or, in some instances, by counsel or other representative, subject to approval by the "unbiased tribunal" which was to be the forum for the hearings on commitment.*

The defendants appealed the judgment of the District Court to this Court pursuant to 28 U.S.C. § 1253.

Probable jurisdiction was noted by the Court on June 19, 1978, and a stay of the lower court's order was granted by Mr. Justice Brennan on July 25, 1978.

SUMMARY OF ARGUMENT

Civil commitment of an individual on grounds of alleged mental illness/retardation is a constitutionally significant deprivation of personal liberty which carries with it serious adverse consequences and disabilities. Such deprivations and disabilities may not constitutionally be imposed without adequate procedural safeguards where the commitment of the individual is involuntary, in fact or in law. Fact finding procedures are particularly important where, as here, the risk of error is substantial, and where, as here, identification of appropriate less restrictive alternatives may obviate the need for commitment to a mental institution.

The asserted interest of the state in providing treatment to mentally disabled juveniles and in preserving the family unit does not justify a substantially different or less stringent application of the Due Process Clause with respect to mental disability commitments of children.

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* This tribunal was not necessarily required to be a court, *Bartley*, 402 F.Supp. at 1049 n.18, *Institutionalized Juveniles*, A. 1082a, and indeed the state was left free to develop alternative procedural safeguards which would be as effective as those specified by the court. *Bartley*, 402 F.Supp. at 1048 n.16, *Institutionalized Juveniles*, A. 1082a.

While parents, of course, can and should be involved in any decision to institutionalize a child, it cannot be assumed in every case that the parent is acting in the best interest of the child. Thus, the final commitment decision should be made, pursuant to appropriate procedures, by an objective and unbiased tribunal.

ARGUMENT

1. Placement in a Mental Institution Is a Constitutionally Significant Deprivation of Liberty and Carries With It Other Serious and Important Adverse Consequences.

Loss of liberty. Commitment to a mental institution necessarily entails a "massive curtailment of liberty," *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972), and inevitably affects "fundamental rights." *Baxstrom* v. *Herold*, 383 U.S. 107, 113 (1966). Perhaps the most basic aspect of constitutional liberty is the right to be free from unwarranted physical confinement. *Arnett* v. *Kennedy*, 416 U.S. 134, 157 (1974). Avoiding extreme restrictions on personal liberty such as those imposed by involuntary civil commitment has been held by this Court to be an interest of "transcending value." *In re Winship*, 397 U.S. 358, 364 (1970).

Although there may be differences between the involuntary commitment of an adult, where the state may assume a more active role, and the commitment of a minor, in which the parents are more directly involved,[7] the

[7] As of 1977 the following states had voluntary commitment statutes allowing parents or guardians to commit minors: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nevada (due process rights, including right to counsel and a hearing, are not forfeited when children are admitted by their parents), New Jersey (modified by state Supreme Court rule November 12, 1974), New Mexico, New York (minor may effect his own releaes), North Carolina (statute declared unconstitutional in *In re Long*, 25 N.C. App. 702, 214 S.E.2d 626 (1975)), North Dakota, Ohio, Oklahoma, Oregon, South Carolina (minor under age 16 may apply for his own release), Tennessee (child may apply for his own release), Utah, Virginia, Washington (consent of minor over age 13 required), West Virginia (minor age 12 and over may apply for his own release), Wisconsin (consent of minor over age 13 required), and Wyoming.

The following states had no age distinction in their voluntary commitment statutes: Iowa, Louisiana, Idaho (but if a parent commits a minor, consent of the parent is required for release), Minnesota, Nebraska, and Rhode Island. A child's consent is required in Delaware, Maine, Montana, and Texas. Alabama considers commitment of a child by his parents to be involuntary commitment. New Hampshire and Vermont specifically exclude children from voluntary commitment procedures. South Dakota has no voluntary commitment statute. "Due Process Limitations on Parental Rights to Commit Children to Mental Institutions," 48 U. Colo. L. Rev. 235, 236 (1977).

results in terms of physical and emotional deprivations are, if different in kind, at least equal in impact and severity.[8] Adults and children alike are deprived of their basic right to personal liberty; all are removed from their homes, communities, and normal daily activities, and are subjected to the custody and control of persons (usually agents of the state) not of their own choosing.

The commitment of a minor to an institution may be a traumatizing disruption of his life which cannot fail to have far-reaching consequences. A committed child is separated from a known environment of family, friends, and school and plunged into a frightening, unfamiliar world. See *In re Gault*, 387 U.S. 1, 27 (1967). As the court in *J.L. and J.R.* v. *Parham*, 412 F.Supp. 112 (M.D. Ga. 1976) put it, perhaps a bit sentimentally but nonetheless accurately:

[8] Parental or familial involvement is not uncommon in the civil commitment of adults. *See O'Connor* v. *Donaldson*, 422 U.S. 563, 565 (1975), where the petitioner was committed at the instance of his parents and spent 15 years in the Florida State Hospital for the mentally ill.

> Like *O'Connor* v. *Donaldson*, 422 U.S. 563, 95 S.Ct. 2486, 45 L.Ed.2d 396, (1975), and the question therein posed and answered, this case raises the most important question of every child's constitutional right to liberty, not only the liberty that includes freedom from bodily restraint, but also the liberty that includes the freedom of an ordinary, every-day child in the United States of America—the freedom to live with mothers, fathers, brothers and sisters in whatever the family abode may be; the freedom to be loved and to be spanked; the freedom to go in and out the door, to run and play, to laugh and cry, to fight and fuss, to stand up and fall down, to play childish games; the freedom to go to school and to frolic with school mates; the freedom to go to Sunday school and church; the freedom to watch and listen or not to watch and listen to television; the freedom to buy candy at the corner store; the freedom to be a normal child in a normal household cared for by normal parents. [*J.L. and J.R.* v. *Parham*, 412 F. Supp. at 136. Footnote and citation omitted.]

Testimony at the trial in this case established the destructive consequences of removing a child from familiar surroundings and the difficulty of subsequent reintegration into his once familiar world (A. 620-621, 990-991).[9] *See* "Minors' Right to Due Process: Does It Extend to Commitment to Mental Institutions?" 52 Notre Dame Law. 136, 140 (1976). The feeling of abandonment occasioned by institutionalization is especially intense for younger children who are adversely affected by such feelings sooner than older children. Goldstein, Solnit & Freud, *Beyond the Best Interest of the Child*, 40-49 (1973). In-

[9] The parties in *Institutionalized Juveniles* stipulated that the evidence admitted in the initial proceeding was to be deemed included in the record of the proceedings in the instant case. *Institutionalized Juveniles*, A. 1066a, n.17. For the convenience of the parties and the Court, the printed Appendix used in this Court in *Bartley* has been used in *Institutionalized Juveniles*.

stitutionalization may also retard the normal intellectual and emotional development of a child.[10] Thus, there is no reason to assume that the institutionalization decision, and the fact of institutionalization, are of any less consequence for minors than for adults (A. 575). If anything, the opposite appears to be the case.

Involuntary treatment. In addition to the deprivation of liberty inherent in an indefinite commitment, such commitment carries with it the risk of physically intrusive treatment which, especially if unwarranted, may violate the committed individual's right to bodily integrity. *See Schmerber* v. *California*, 384 U.S. 757, 772 (1966); *Rochin* v. *California*, 342 U.S. 165 (1952). Such treatment modalities may include forced administration of psychotropic medication, *see Winters* v. *Miller*, 446 F.2d 65 (2nd Cir. 1971), *cert. den.* 404 U.S. 985 (1971); *Scott* v. *Plante*, 532 F.2d 939 (3rd Cir. 1976); *Souder* v. *McGuire*, 423 F.Supp. 830 (M.D. Pa. 1976); aversive conditioning, *see Knecht* v. *Gillman*, 488 F.2d 1136 (8th Cir. 1973); *Mackey* v. *Procunier*, 477 F.2d 877 (9th Cir. 1973); *Wyatt* v. *Hardin*, No. 3195-N (M.D. Ala. February 28, 1975, June 26, 1975, and July 1, 1975), 1 MDLR 55; convulsive therapy, *see Wyatt* v. *Hardin*, *supra*; *Price* v. *Sheppard*, 239 N.W. 2d 905 (Minn. 1976), 1 MDLR 120; *Nelson* v. *Hudspeth*, C.A. No. J75-40(R) (S.D. Miss. May 16, 1977); and even psychosurgery, *see Kaimowitz* v. *Michigan Department of Mental Health*, No. 73-19434-AW (Cir. Ct. Wayne County, Mich., July 10, 1973), 1 MDLR 147.[11]

[10] Glenn, "The Least Restrictive Alternative in Residential Care and the Principle of Normalization," in *The Mentally Retarded Citizen and the Law*, at 499-501 (1976); Hobbs (ed.), *Issues in the Classification of Children*, at 135, 142-143 (1975); Joint Commission on the Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970's*, at 321-324, 330-331 (1970); Provence & Lipton, *Infants in Institutions*, at 19 (1962).

[11] *See generally* Friedman, "Legal Regulation of Applied Behavioral Analysis in Mental Institutions and Prisons," 17 Ariz. L.

Of course, not every institutionalized minor will be subjected to hazardous or intrusive procedures, but the fact is that institutionalization, to some degree, confers upon the state (or perhaps upon a private facility through the authority of the state) the power to impose treatment upon an institutionalized individual—treatment which by its very nature may involve "impermissible tinkering with mental processes," *Mackey* v. *Procunier*, *supra*, 477 F.2d at 877, or a violation of the right to privacy. *See Roe* v. *Wade*, 410 U.S. 113 (1973); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965). Obviously, no one, especially a child, should be exposed to the risk of such treatment without prior determination that it is warranted and appropriate.

Stigmatization. As courts have noted,[12] institutionalization on mental disability grounds almost inevitably stigmatizes the individual involved in a way that adversely affects him the rest of his life. Such stigmatization may result in or be accompaniedb y the scorn or obloquy of one's peers, loss of employment possibilities and education benefits, and other civil disabilities that flow from institutionalization (A. 569, 574-575, 621-622, 634, 657).[13]

Rev. 39 (1975), and Plotkin, "Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment," 72 Nw. L. Rev. 461 (1978).

[12] *E.g.*, *Lessard* v. *Schmidt*, 349 F.Supp. 1078, 1088-90 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 473 (1974), *on remand*, 379 F.Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1975), *on remand*, 413 F.Supp. 1318 (E.D. Wis. 1976); *In re Roger S.*, 141 Cal. Rptr. 298, 569 P.2d 1286 (Cal. 1977).

[13] *Cf.* Comment, "Developments in the Law—Civil Commitment of the Mentally Ill," 87 Harv. L. Rev. 1190, 1198-1201 (1974) (committed persons "may suffer from the social opprobrium which attaches to treatment for mental illness and which may have more severe consequences then do formally imposed disabilities." Note 6 at 1200.). *Goss* v. *Lopez*, 419 U.S. 565, 579 (1975) ("[Charges of misconduct] could seriously damage the students' standing with their

In these circumstances, *see Paul* v. *Davis*, 424 U.S. 693, 701-705 (1976), an individual's interest in his good reputation is a liberty (or property) interest entitled to constitutional protection. *Board of Regents* v. *Roth*, 408 U.S. 564, 573 (1972); *Wisconsin* v. *Constantineau*, 400 U.S. 433 (1971).

The social stigma attached to institutionalization for either mental illness or mental retardation has been well-documented. The President's Commission on Mental Health found the public frightened and repelled by the term "mental illness." *Report to the President*, *supra*, at 55. The Commission's findings confirm the expert testimony in the record in this case regarding stigma, cited immediately above.[14] The Commission's Task Panel on Public Attitudes and Use of Media for Promotion of Mental Health (Appendix-Vol. IV) reported that "ignorance, prejudice, and fear of 'mental illness' and the 'mentally ill' remain widespread throughout America," and attributed much of this stigma to continuing uncertainty regarding causes and cures of mental illness. *Id.* at 1867. The Task Panel further found that the general public is often influenced by news accounts and the popular media, and equates mental illness with violent and anti-social behavior. *Id.*[15]

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fellow pupils and teachers as well as interfere with later opportunities for higher education and employment [footnote omitted]."). *In re Ballay*, 482 F.2d 648, 667-669 (D.C. Cir. 1973). *In re Coleman*, Cir. Ct. No. 76-639-949 AV (Cir. Ct. Wayne County, Mich., Feb. 23, 1977). *See also* "Minors' Right to Due Process," *supra*, 52 Notre Dame Law. at 140.

[14] *See also* Sarbin & Mancuso, "Failure of a Moral Enterprise: Attitudes of the Public Toward Mental Illness," 35 J. Consulting & Clinical Psych. 159 (1970); Fracchia, *et al.*, "Public Views of Ex-Mental Patients: A Note on Perceived Dangerousness and Unpredictability," 38 Psych. Rep. 495 (1976).

[15] This negative public attitude is likewise reflected in the broad range of civil disabilities legislatively imposed upon persons labeled "mentally ill." *See* Note, "Mental Illness: A Suspect Classification?," 83 Yale L.J. 1237 (1974).

The label of mental illness often results in discrimination against the person to whom it is applied. It has been observed that "[k]nowledge of previous psychiatric treatment and/or the possession of a phychiatric label is . . . used prejudiciously to exclude individuals. . . ." American Psychiatric Association, "Position Statement on Discrimination Against Persons with Previous Psychiatric Treatment," 135 Am. J. Psy. 643, 644 (1978). The degree of stigmatization has been found to increase proportionately with the level of treatment and official intervention (Bord, "Rejection of the Mentally Ill: Continuities and Further Developments," 18 Soc. Prob. 496 (1971)), and to produce negative expectations among those whom the person later encounters. This is particularly true in the area of employment, where studies have found potential employers reluctant to hire former patients because such employees are believed to cause problems, to require increased supervision, and to be less responsible.[16]

The stigma of being labeled mentally retarded may be even more devastating, and has been called "uniquely damaging." Teitelbaum and Ellis, "The Liberty Interest of Children: Due Process Rights and Their Application," 12 Fam. L.Q. 153, at 31 (manuscript) (Fall, 1978) (hereinafter cited as Teitelbaum and Ellis. Page citations herein are to manuscript submitted for publication.) The label implies that its holder is incompetent in all areas of practical affairs, and is particularly burdensome in a society such as ours which places a premium on intelligence. *Id.* In addition, retardation, unlike mental illness, is viewed as permanent and incurable. Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded*, 207 (1967); *see* Severance & Gasstrom, "Effects of the Label 'Mentally Retarded' on Causal

[16] Howard, "The Ex-Mental Patient as an Employee," 45 Am. J. Orthopsych. 479, 479-80 (1975).

Explanations for Success and Failure Outcomes," 81 Am. J. Men. Def. 547 (1977). The label has been seen to foreclose vocational options (even when employed, the retarded arte often relegated to unskilled or semi-skilled occupations), and to deny participation in social activities "average" persons take for granted (for example, retarded persons are often prevented from entering into contracts or obtaining driver's licenses). *See* President's Committee on Mental Retardation, *The Mentally Retarded Citizen and the Law*, 214, 220 (1976).

Moreover, the label of mental retardation has a profound effect on the self-image of the person to whom it is applied, almost guaranteeing a "failure life pattern." *The Mentally Retarded Citizen and the Law*, *supra*, at 221.

> To find oneself regarded as a mental retardate is to be burdened by a shattering stigma. . . . These persons cannot both believe that they are mentally retarded and still maintain their self-esteem. . . . [T]he stigma of mental retardation dominates every feature of the lives of these former patients. Without an understanding of this point there can be no understanding of their lives. [*Cloak of Competence*, *supra*, at 204-208.]

The stigma associated with mental retardation is strikingly revealed in the experience of mildly retarded persons who, once released from institutions, often deny the nature of their past confinement: "They employ almost any other excuse, from epilepsy to 'craziness'—excuses that are themselves highly stigmatizing. Never is mental retardation mentioned." *Id.* at 207.

Possibility of inhumane or inadequate treatment. It is unfortunate but true that many of our nation's mental institutions do not provide minimally adequate habilitative or rehabilitative programming, but in fact may subject their patients or residents to inhumane and unsafe

living conditions, destructive psychological pressures, and even physical abuse by other patients or residents or by staff members, all in violation of constitutional guarantees. The President's Commission on Mental Health, in recommending the establishment of advocacy programs for the mentally disabled, has stated that "[w]e are keenly aware that even the best intentioned efforts to deliver services to mentally disabled persons have historically resulted in well-documented cases of exploitation and abuse." *Report to the President, supra*, at 42. As in *In re Gault, supra*, 387 U.S. at 15-21, this Court should take note of this possibility, which has been well-documented by lower federal courts,[17] in determining the procedural protections which should attend the commitment of anyone, especially a child, to a mental institution. In those jurisdictions where substandard conditions exist, the consequences of erroneous institutionalization decisions are especially grave.

[17] *E.g., O'Connor* v. *Donaldson, supra; Wheeler* v. *Glass*, 473 F.2d 983 (7th Cir. 1973); *Evans* v. *Washington*, C.A. No. 76-0293 (D.D.C. June 14, 1978) (consent order); *Wouri* v. *Zitnay*, Civ. No. 75-80-SD (S.D. Maine July 14, 1978) (consent order); *Halderman* v. *Pennhurst State School and Hospital*, 446 F.2d 1295 (E.D. Pa. 1977); *Davis* v. *Watkins*, 384 F.Supp. 1196 (N.D. Ohio 1974); *Welsch* v. *Likins*, 373 F.Supp. 487 (D. Minn. 1974), *enforced*, No. 4-72-Civ. 451 (D. Minn. October 1, 1974), 1 MDLR 193, *aff'd in part* 550 F.2d 112 (8th Cir. 1977), 1 MDLR 334; *New York State Association for Retarded Children and Parisi* v. *Rockefeller*, 357 F.Supp. 752 (E.D.N.Y. 1973), *modified*, No. 72-C-356/357 (E.D.N.Y. May 23, 1973), *order on consent sub nom. New York State Association for Retarded Children and Parisi* v. *Carey*, No. 72-C-356/357 (E.D.N.Y. April 30, 1975), *approved*, 393 F.Supp. 715 (E.D.N.Y. 1975), 1 MDLR 58; *Romeo* v. *Youngberg*, C.A. No. 76-3429 (E.D. Pa. June 6, 1977); *Vanderzeil* v. *Hudspeth*, C.A. No. J76-262 (R) (S.D. Miss. Feb. 11, 1977); *Horacek* v. *Exon*, 354 F.Supp. 71 (D. Neb. 1973), *order on consent*, No. 72-L-299 (D. Neb. October 31, 1975); *Wyatt* v. *Stickney*, 325 F.Supp. 781 (M.D. Ala. 1971), 334 F.Supp. 1341 (M.D. Ala. 1971), 344 F.Supp. 373 and 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974). *Cf.* Gruenberg, "The Social Breakdown Syndrome—Some Origins," 123 Am. J. Psychiatry 12 (1967); Barton, *Institutional Neurosis* (2d ed. 1966); Goffman, *Asylums* (1961).

As with all the other types of deprivations and adverse consequences cited in this part, no reason appears why such infringements of constitutionally protected rights are of any less consequence in the case of children than they are in the case of adults (A. 575).

Deleterious effect on intellectual and emotional development. Prolonged institutional treatment of mentally ill or retarded children presents the threat of serious long-term effects on cognitive, emotional and social development, and therefore should be considered only as a last resort. *See*, Glasscote *et al.*, *Children and Mental Health Centers*, 20 (1972); Joint Commission Report, *Crisis in Child Mental Health, supra*, at 269; A. 474-475a, 582a, 590a, 620-622a, 631a, 633-634a. Studies of young children in institutions document that "most infants living in institutions do not get enough mothering [considered necessary for the formation of close personal relationships and the development of inner-self controls] in purely quantitative terms." Provence & Lipton, *supra*, at 19 (1962). Further, a child growing in an institution rarely receives the individualized responses necessary as he experiments in physical and mental skill development. *See*, Flint, *The Child and the Institution*, 16 (1966); Bowlby, *Child Care and Growth of Love*, 61 (1953). Children in institutions are also unlikely to be exposed to the stimuli and challenges necessary to a growing child. *The Child and the Institution, supra*, at 15. Nor does life in an institution offer children opportunity for integration into community life. Since they are denied community contact, the behavior of institutionalized children "as young adults reflects their lack of contact with normal people during their developmental period." Leland & D. Smith, *Mental Retardation: Present and Future Perspectives*, 86 (1974); Glenn, *supra*, at 499.

The resulting psychological and developmental harms are manifold. Institutionalized children or adolescents

typically have low scores on intelligence tests, poor progress in school, and deficiencies in emotional and social development. Studies indicate that these harms accelerate with the length of institutionalization, the age at which the child was first admitted, and the conditions in the institution. Hobbs, *The Futures of Children*, 135, 142-143 (1975). These deficiencies typically persist even after the institutionalized infant is removed to a family environment.[18]

Mentally retarded children, particularly the young, are even more profoundly affected by institutionalization. Several studies comparing the development of institutionalized retarded children with non-institutionalized retarded children clearly demonstrate the superior development of non-institutionalized retarded children. *See* Stimpson, *et al.*, "Effects of Early Institutionalization on Growth and Development of Young Children with Down's Syndrome," 67 Mich. Med. 1213 (1968); Centerwell and Centerwell, "A Study of Children with Mongolism Reared in the Home," 25 Pediatrics 678 (1961) (comparisons of matched institutionalized and non-institutionalized children afflicted with mongolism show consistently higher IQ's in home-reared children); Lyle, "The Effect of an Institution Environment Upon the Verbal Development of Imbecile Children," 1 J. Men. Def. Res. 1, 12, 21 (1960); Sternlight and Seigel, "Institutional Residence and Intellectual Functioning," 12 J. Men. Def. Res. 119, 123 (1968) (similar findings as to comparative verbal functioning between non-institutionalized and institutionalized retarded children, with the difference in verbal ability attributed to the institutional environment itself); and

[18] Provence & Lipton, *supra*, at 150-155. *See also* Youngleson, "The Need to Affiliate and Self-Esteem in Institutionalized Children," 26 J. Personality and Soc. Psychology 280 (1973); Tizard & Rees, "The Effect of Early Institutional Rearing on the Behavior Problems and Affectional Relationships of Four-Year-Old Children," 16 J. Child Psychology-Psychiatry 61 (1975).

Kaufman, "The Formation of a Learning Set in Institutionalized and Non-Institutionalized Mental Defectives," 67 Am. J. Men. Def. 601, 604 (1963) (comparison of matched groups of institutionalized and non-institutionalized mentally retarded children demonstrates superior ability of non-institutionalized children to form learning sets, *i.e.*, to learn from experience). Other studies suggest that institutionalized retarded children's motor development is inhibited by conditions of institutional confinement such as lack of stimulation, enforced quiescence, and verbal chastisement following active or experimental behavior.[19]

2. Confinement in a Mental Institution Cannot Be Constitutionally Imposed by the State or Under the Authority of State Law Without Adequate Procedural Safeguards.

This Court has repeatedly determined that prior to a deprivation of a constitutionally protected interest, the Due Process Clause demands that procedures be established to determine the necessity and legal justification for the proposed deprivation. This Court has adopted a flexible approach by tailoring the procedural requirements according to the weight of the competing individual, governmental or societal interests at stake. *See, e.g.*, *Matthews* v. *Eldridge*, 424 U.S. 319 (1976);[20] *Wolff* v. *Mc-*

[19] Klaber & Butterfield, "Stereotyped Rocking—A Measure of Institution and Ward Effectiveness," 73 Am. J. Men. Def. 13, 18-19 (1968); Kaufman, "The Effects of Institutionalization on Development of Stereotyped and Social Behaviors in Mental Defectives," 71 Am. J. Men. Def. 581 (1967); Mosley, *et al.*, "Effects of Social and Non-Social Stimuli on the Stereotyped Behaviors of Retarded Children," 74 Am. J. Men. Def. 809 (1970).

[20] *Matthews* is the most recent enunciation by this Court of the factors to be considered in determining the adequacy of due process procedures. These factors are: 1) the private interest that will be affected by the official action; 2) the risk of erroneous deprivation under existing procedures, and the value of alternate procedural safeguards; and 3) the government's interest, including the burden

Donnell, 418 U.S. 539 (1974); *Morrissey* v. *Brewer*, 408 U.S. 471, 481-90 (1972); *Bell* v. *Burson*, 402 U.S. 535, 539-42 (1971); *Boddie* v. *Connecticut*, 401 U.S. 371 (1971); *Goldberg* v. *Kelly*, 397 U.S. 254, 263-71 (1970); *Cafeteria Workers Union* v. *McElroy*, 367 U.S. 886, 895 (1961).

While this Court has not ruled directly on the procedural requirements for civil mental disability commitments, it has mandated strict procedural safeguards in the analogous areas of quasi-criminal commitments, *Specht* v. *Patterson*, 386 U.S. 605 (1967), and institutionalization of juvenile delinquents, *e.g.*, *In re Winship*, *supra*; *In re Gault*, *supra*. Indeed, the Chief Justice noted in his concurring opinion in *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 580, that

> [t]here can be no doubt that involuntary commitment to a mental institution, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law. . . . Commitment must be justified on the basis of legitimate state interest, and the reason for committing a particular individual must be established in an appropriate proceeding. [Citations omitted.]

Numerous lower federal courts, relying in part on the above-cited cases, have struck down civil commitment

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imposed by alternate procedures. For an exhaustive analysis of "voluntary" commitment of allegedly mentally retarded children in terms of the *Matthews* criteria, see generally, Teitelbaum and Ellis, *supra*.

This Court has recently emphasized the importance of preventing erroneous deprivations of protected rights:

> Procedural due process rules are meant to protect persons not from deprivation, but from the mistaken or unjustified deprivation of life, liberty, or property. Thus, in deciding what process constitutionally is due in various contexts, the Court repeatedly has emphasized that "procedural due process rules are shaped by the risk of error inherent in the truth-finding process. . . ." [*Carey* v. *Piphus*, 98 S.Ct. 1042, 1050 (March 21, 1978). (Citations omitted.)]

statutes found to be deficient in procedural safeguards. *Stamus* v. *Leonhardt*, 414 F.Supp. 439 (S.D. Iowa 1976); *Suzuki* v. *Quisenberry*, 411 F.Supp. 1113 (D. Hawaii 1976), 1 MDLR 46; *Goldy* v. *Beal*, 429 F.Supp. 640 (M.D. Pa. 1976), 1 MDLR 137; *Doremus* v. *Farrell*, 407 F. Supp. 509 (D. Neb. 1975); *Kendall* v. *True*, 391 F.Supp. 413 (W.D. Ky. 1975); *Lynch* v. *Baxley*, 386 F.Supp. 378 (M.D. Ala. 1974); *Bell* v. *Wayne County*, 384 F. Supp. 1085 (E.D. Mich. 1974); *Lessard* v. *Schmidt*, *supra*; *Dixon* v. *Attorney General of the Commonwealth of Pennsylvania*, 325 F.Supp. 966 (M.D. Pa. 1971). *Cf. State ex rel. Hawks* v. *Lazaro*, 202 S.E. 2d 109 (W. Va. 1974); *Denton* v. *Commonwealth*, 383 S.W. 2d 681 (Ky. 1964).

Deficiencies in procedural safeguards attending civil commitments have also caused concern in other quarters, and recently have been scrutinized by two nationally prominent groups. The President's Commission on Mental Health, in its *Report to the President*, *supra*, at 43 recommended that "[e]ach state review its civil commitment and guardianship laws and revise them, if necessary, to incorporate increased procedural protections." The annotation to the recommendation cites various procedural safeguards deemed appropriate, including the rights to present evidence, to subpoena and cross-examine witnesses, and to be represented by counsel. *Id.* at 70-71.

The American Bar Association has echoed the concern of the President's Commission, and has gone on record in support of adequate procedures in the civil commitment area. At the Association's Annual Meeting in August 1978, the House of Delegates endorsed the foregoing recommendation, together with other human rights recommendations made by the President's Commission.[21]

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[21] The complete text of the House of Delegates' policy statement commending, and in part endorsing, the Report of the President's Commission on Mental Health may be found at Appendix B.

The application of such procedural safeguards to the "voluntary" commitment of children on mental disability grounds is well established in the lower courts. Indeed, many courts other than the District Court in the instant case have similarly held due process requirements to be specifically applicable to mental disability commitments of children. *J.L. and J.R.* v. *Parham, supra; In re Roger S., supra; Saville* v. *Treadway*, 404 F.Supp. 430 (M.D. Tenn. 1974); *Kidd* v. *Schmidt*, 399 F.Supp. 301 (E.D. Wis. 1975); *In re Long*, 25 N.C. App. 702, 214 S.E. 2d 626 (Ct. App. N.C. 1975). *Cf. Pima County Public Fiduciary* v. *Superior Court*, 546 P.2d 354 (Ariz. Ct. App. 1976).

A. *The District Court's Emphasis on the Right to Adequate Notice and to Counsel Was Appropriate in Light of Applicable Precedent and the Factual Record.*

The lower court cases have concluded, in particular, that the requirements of due process include the right to meaningful notice given sufficiently in advance of any proceedings so as to apprise the individual of the grounds for the proposed commitment along with the procedural and substantive rights afforded him. *Suzuki* v. *Quisenberry, supra*, 411 F.Supp. at 1127; *Doremus* v. *Farrell, supra*, 407 F.Supp. at 515; *Lynch* v. *Baxley, supra*, 386 F.Supp. at 388; *Bell* v. *Wayne County, supra*, 384 F. Supp. at 1092; *Lessard* v. *Schmidt, supra*, 349 F.Supp. at 1092. In addition, the lower court opinions have uniformly held that an individual faced with the prospect of involuntary commitment for an indefinite period is entitled to the effective assistance of counsel, including the appointment of counsel if the individual cannot afford retained counsel, and that counsel must be made available far enough in advance of any hearing to provide adequate opportunity for preparation. *Suzuki* v. *Quisenberry, supra*, 411 F.Supp. at 1129; *Doremus* v. *Farrell, supra*,

407 F.Supp. at 516; *Lynch* v. *Baxley, supra*, 386 F. Supp. at 389; *Bell* v. *Wayne County, supra*, 384 F.Supp. at 1093-94; *Lessard* v. *Schmidt, supra*, 349 F.Supp. at 1097-98. *Cf. Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968).

In the instant case, the court mandated that notice and the appointment of counsel or other trained representative be nonwaivable, although other procedural requirements may be waived if an unbiased tribunal finds that such a waiver is in the best interest of the child. *Bartley*, 402 F.Supp. at 1053 n.26; Order of November 17, 1975 (A. 831), *Institutionalized Juveniles*, A. 1094a, 1096a, and 1098a. This approach takes into account the unique aspects of a juvenile mental disability commitment, where the child may in certain situations be subject to more implicit or explicit coercion and less likely to appreciate or comprehend the nature of the proceedings,[22] and in other cases may, after consultation with counsel, be in a position to dispense with other formal procedures. Thus the court below merely adopted a logical method to prevent abusive practices in securing waivers and to eliminate time-consuming and unnecessary challenges to a child's commitment.

Supplementing the legal authority for the appointment of counsel[23] was testimony by mental disability experts at the trial who agreed that counsel played an important therapeutic role in the proceedings for all involved. The testimony indicated that the advocate for the child is the only individual who can be perceived by the child as representing his or her interests in the commitment pro-

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[22] *See* A. 590, 630-631, 1019a.

[23] *See also* "Minors' Right to Due Process," *supra*, 52 Notre Dame Law. at 142, 144, which advocates "[t]he appointment of *medical and legal* advocates . . . [as] an appropriate means of ensuring that the child's interests are given full judicial consideration" (at 144, emphasis added).

ceedings. Despite assurances to the contrary from parents or the psychiatrist, the child is likely to perceive their roles as adversarial. Appointment of counsel for the child thus decreases the chance that the child will feel "railroaded" and makes him or her more amenable to treatment if commitment is ordered (A. 542-544, 1014a-1015a).

B. *The Right to Counsel, in Particular, Has Been Emphasized by the American Bar Association as a Matter of Sound Judicial Administration.*

Appointment of counsel along the lines of the lower court's order has been incorporated into the *Standards Relating to Trial Courts* drafted by the American Bar Association Commission on Standards of Judicial Administration and adopted by the Association's House of Delegates at its mid-year meeting in February, 1976.[24] Section 2.72 of the trial court standards,[25] which sets forth the procedural requirements for civil commitment proceedings, specifically provides that persons subject to such proceedings are entitled to the assistance of counsel as provided in Section 2.20. That section, in addition to permitting a litigant to employ counsel in any judicial proceeding, requires that counsel be appointed for persons unable to afford their own counsel when they are "subject to a civil proceeding in which the result may be detention for a period of longer than 72 hours."

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[24] The Association's House of Delegates has also adopted policies urging the establishment of advocacy programs for the mentally disabled in all states and "recognizing the importance of counsel to represent not only the mentally disabled client (or those acting in his or her behalf) but also the state or provider against which a claim is made" in adversary or judicial settings. (For full texts, see Appendix B to this brief.)

[25] The complete text of Section 2.72 and accompanying Commentary are attached as Appendix A to this brief.

In its commentary with regard to this standard, the Commission on Standards of Judicial Administration noted:

> In addition to representation in criminal cases, counsel should be appointed to represent any person who is the subject of a civil proceeding in which the result may be his physical commitment or detention. Such proceedings include commitment of the mentally ill, mentally deficient, narcotics addicts, alcoholics, "defective delinquents," "sexual psychopaths," and similarly defined persons. The distinction between these procedures and criminal prosecution is often more theoretical than real, for the state plays an adversary role, as in criminal cases, and the consequence of adjudication may be long confinement—sometimes for an indefinite period—in an institution where the conditions of custody to a greater or lesser degree resemble a prison. A like necessity for counsel exists in deportation and contempt proceedings. Where the individual involved is mentally disturbed or deficient, or lacks facility in speaking English, the need for counsel is all the more urgent because the person cannot speak effectively for himself.

Clearly, the commitment of a minor falls within the type of situation contemplated by Standard 2.20.[26]

As noted *supra*, the court below enumerated other procedural rights for children facing commitment, all of which find support in some or all of the authorities

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[26] The critical role of counsel for children is also discussed at length in draft standards relating to the juvenile justice system which were recently published by the Juvenile Justice Standards Project. The Project, a joint venture of the Institute of Judicial Administration and American Bar Association, has produced a draft twenty-three volume series covering the entire field of juvenile justice administration. At present, the standards have not been approved by the American Bar Association, but are scheduled to be considered at the Association's 1979 mid-year meeting. IJA-ABA, *Standards Relating to Counsel for Private Parties* (Tent. Draft, 1977).

supporting *amicus*' arguments herein.[27] *Amicus* would point out also that Section 2.72 of the above described trial court standards and the order entered by the court below are strikingly similar, in that both contemplate a preliminary and final hearing, the right to notice, counsel, and personal presence at such hearings, along with the rights of confrontation and cross-examination and of presenting evidence on one's own behalf.

C. *The District Court Was Correct in Finding That the Pennsylvania Scheme for Admission or Commitment of Children Does Not Satisfy the Requirements Enumerated Above.*

A plain reading of the commitment scheme established by Pennsylvania law[28] demonstrates that it affords children subject to institutionalization none of the procedural safeguards mandated by the above cited constitutional decisions or endorsed by the American Bar Association.

The overriding flaw in the challenged procedure is its failure to require a hearing in all cases, absent a valid waiver. Equally important, the Pennsylvania approach fails to require that such a hearing be held before an unbiased tribunal, and that counsel or other trained representative be appointed. The 1973 Regulations fail to cure, and the 1976 Act perpetuates, these fatal defects.

Neither Sections 402 and 403 of the 1966 Act, nor the 1973 Regulations, require any hearing prior to admission/commitment. Rather, they provide for referral and evalu-

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[27] The utility of particular procedural safeguards may vary to some extent depending on the age and maturity of the child involved.

[28] Sections 402 and 403 of the 1966 Act (50 P.S. §§ 4402 and 4403), together with the 1973 Regulations (3 Pa. Bull. 1840 (1973)) govern the admission/commitment of children alleged to be mentally retarded. Sections 201 and 206 of the 1976 Act, and to the extent it applies to children under age 14, Section 205 of that Act (50 P.S. §§ 7201, 7206, and 7205) govern the commitment of children alleged to be mentally ill.

ation, subject to the institution director's independent examination. This structure was found by the expert witnesses to be inherently unreliable.[29] Moreover, the expert witnesses concluded that placing sole reliance on psychiatric, psychological, or other professional diagnosis without recourse to review by an unbiased tribunal, will not suffice to prevent unnecessary or inappropriate commitments (A. 550, 585, 604, 1006-11a).[30]

These provisions also fail to provide for the automatic appointment of an advocate to represent the child's interest. Further, the nominal safeguards contained in the 1973 Regulations are inapplicable to children under age 13.

The 1976 Act perpetuates the flaws of the earlier provisions by failing to require any hearing. Although Section 205 (50 P.S. § 7205) requires an "individualized treatment plan" for each child, it fails to assure the independence of the treatment team formulating the plan. Thus, this procedure is essentially similar to that found

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[29] In summary, these experts felt that the regulations did not ensure adequate evaluation of the child; that there was a tendency for psychiatrists to agree among themselves for reasons unrelated to the needs of the patient; that admitting psychiatrists at an institution may be unduly influenced by institutional demands; that once institutionalized, individuals tend to accede to the institution's point of view, and in spite of the notice requirements, an individual may not be able to express his objections (A. 558, 561, 598, 628-629, 630-631). It should also be noted that the Regulations contain no assurance that the interests of the child will be weighed in making the commitment decision (A. 1084a-1085a).

[30] *See also*, Teitelbaum and Ellis, *supra*, at 44:

> At first glance, it might appear that the involvement of such professionals [physicians or other professionals] would provide sufficient check on ill-advised parental action and that additional protections would be unnecessary. However, as is the case of parental commitment of children as mentally ill, the professionals involved do not adequately perform the function of screening out children who are inappropriate for institutionalization. [Footnote omitted.]

unacceptable by the expert witnesses considering the 1973 Regulations (n.29 *supra;* A. 1086 at n.60). In addition, the 1976 Act fails to require a post-commitment hearing within a reasonable time after commitment, thus subjecting it to the above criticism of placing sole reliance on psychiatric opinion. Finally, the 1976 Act has no provision requiring that an advocate be appointed to represent the interests of the child.

D. *The Labeling of Juvenile Mental Disability Commitments As Civil (Rather Than Criminal), Benevolent, or Voluntary Does Not Affect the Applicability of the Due Process Clause.*

This Court has long avoided the labeling of a particular proceeding as "civil" rather than "criminal" and has imposed due process requirements when it was clear that the potential existed for serious deprivation of constitutionally protected interests. *E.g., Breed* v. *Jones*, 421 U.S. 519, 530 (1975); *In re Gault, supra; Specht* v. *Patterson, supra; cf. Heryford* v. *Parker, supra*, 396 F.2d at 396. The same deprivations threatened in these prior juvenile and quasi-criminal "civil" proceedings are present here, and the same reasoning should apply. *Institutionalized Juveniles*, A. 1077a. Appellants in their brief to this Court attempt to circumvent this authority by contrasting the medical determination in the present case to the finding of guilt in *In re Gault*. Appellant's brief, p. 41. This reasoning ignores the essence of these cases, which turn on the nature of deprivation involved. Finally, the statutory characterization of these admissions and commitments as "voluntary" should not mask the fact that they are voluntary on the part of the parent (or other person or agency seeking institutionalization), but not on the part of the child being deprived of his liberty. Thus, the requirements of due process should apply.

E. *The Imposition of Due Process Protections Upon the Institutionalization Decision is Necessitated Both by the Risk of Erroneous Psychiatric and Other Judgments and by the Need to Ensure That Less Restrictive Alternatives Are Adequately Explored.*

The deprivation and consequences of institutionalization described in the first section of *amicus*' argument would, in themselves, require that institutionalization decisions made by or through the authority of the state be subject to the requirements of the Due Process Clause. The special nature of the admission/commitment decision, however, demands the type of procedural safeguards mandated by the District Court for at least two further reasons—the uncertainty of psychiatric (and other) diagnoses and the need, from both a professional and constitutional standpoint, to place an allegedly mentally disabled person in the least restrictive setting which will meet his treatment needs.

The Chief Justice has recently noted the "uncertainties" of diagnosis and therapy in the "baffling" field of psychiatry and has observed, correctly, that "the reported cases are replete with evidence of the divergence of medical opinion in this vexing area." *O'Connor* v. *Donaldson*, 422 U.S. at 579 (Burger, C.J., concurring). This Court has previously remarked upon "the uncertainty of diagnosis in this field and the tentativeness of professional judgment." *Greenwood* v. *United States*, 350 U.S. 366, 375 (1956); *cf.* Ennis & Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," 62 Calif. L. Rev. 693 (1974). Diagnosis of mental retardation is equally uncertain[31] (A. 979a-

[31] *See e.g.*, Menolascino, "Emotional Disturbance and Mental Retardation," 70 Am. J. Men. Def. 248, 250 (1965), which found that of 616 children identified as mentally retarded, 191 had predominantly psychiatric problems (for whom mental retardation treatment offered no help, and who might well have been more appro-

982a; Teitelbaum and Ellis, *supra*, pp. 35-47), especially in the case of very young children. Teitelbaum and Ellis, *supra*, at 38.

Expert testimony in the instant case indicated that an admission/commitment hearing, or even the knowledge that a hearing may be requested, will encourage psychiatrists to exercise greater care in evaluating prospective patients and thus diminish the chance for an erroneous decision (A. 543-44, 640-41). The pendency of a hearing will also dilute the tendency of some psychiatrists to overdiagnose or to err on the side of caution, assuming disease over health. *See* Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions," 62 Calif. L.Rev. 840, 865 (1974); Rosenhan, "On Being Sane in Insane Places," 113 Santa Clara L. Rev. 379 (1973). Given the uncertainties in the field of mental disability, and the difficulty in relating psychiatric or psychological diagnoses to legal standards for commitment,[32] proper fact-finding procedures are a practical and constitutional necessity in the civil commitment process (A. 1008a-9a).

Moreover, it is no longer open to serious question that state-imposed deprivation of personal liberty for purposes of mental disability treatment, or any other such incursion on constitutionally protected liberties, must be only to the limited extent necessary to accomplish the legitimate purpose of the deprivation or limitation in question. *Shelton* v. *Tucker*, 364 U.S. 479, 488-490 (1960). Numerous lower federal courts have recognized

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priately treated in some other way), and 40 were found to be not mentally retarded at all.

[32] Shah, "Dangerousness: Some Definitional, Conceptual, and Public Policy Issues," in *Perspectiveness in Law and Psychology* (B. Sales ed. 1977); Shah, "Some Interactions of Law and Mental Health in the Handling of Social Deviance," 23 Catholic U. L. Rev. 647 (1974).

the applicability of this "least restrictive alternative" doctrine to commitment and treatment of the mentally disabled. *Halderman* v. *Pennhurst State School and Hospital, supra; Wouri* v. *Zitnay, supra; Evans* v. *Washington, supra; New York State Association for Retarded Children and Parisi* v. *Carey, supra*, Order of April 30, 1975, 1 MDLR 58; *Lynch* v. *Baxley, supra*, 386 F.Supp. at 392; *Welsch* v. *Likins, supra*, 373 F.Supp. at 501-502; *Lessard* v. *Schmidt, supra*, 349 F.Supp. at 1096; *Wyatt* v. *Stickney, supra*, 344 F.Supp. at 379, 396; *cf. Dixon v. Weinberger*, 405 F.Supp. 974 (D.D.C. 1975),[33] 1 MDLR 12; *Covington* v. *Harris*, 419 F.2d 617 (D.C. Cir. 1969); *Lake* v. *Cameron*, 364 F.2d 657 (D.C. Cir. 1966). Indeed, this Court has specifically applied this rationale to mental disability commitments in *O'Connor* v. *Donaldson, supra*, 422 U.S. at 575:

> May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom on their own or with the help of family or friends. See *Shelton* v. *Tucker*, 364 U.S. 479, 488-490.

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[33] In this case, based on the 1964 Hospitalization of the Mentally Ill Act, 21 D.C. Code §§ 501ff., the District Court, in endorsing the least restrictive approach to both commitment and treatment, found not only that some patients in the District of Columbia's mental hospital could fare as well in the community, but also that the treatment needs of 43% of the patients *required* them to be in the community. 405 F.Supp. at 976.

The expert testimony in this case (A. 476-77, 577, 619-621) and the professional literature[34] are in accord with the foregoing legal analysis. Insofar as the class of mentally retarded children is concerned, the testimony revealed little or no benefit in institutionalizing a child and indeed that irreversible harm may very likely result. (A. 991a-92a). Thus, perhaps the most vital function of procedures such as those required by the court below is to prod the parents, professionals, and others involved in the admission/commitment process to avoid unnecessary and inappropriate institutionalization and, if necessary, to invest the resources of other social agencies and the committing tribunal in identifying or creating treatment alternatives which will not unduly limit the personal freedom (or the therapeutic prognosis) of the individual facing commitment.

3. Children Facing Commitment on Mental Disability Grounds are Entitled to Substantially the Same Procedural Protections Afforded Adults Under the Due Process Clause.

As noted above, admission/commitment of children to mental institutions involves at least an equivalent degree of deprivations and risks, and is subject to the same possibility of erroneous or inappropriate diagnosis or

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[34] Glenn, *supra*, at 499-514; Wolfensberger, *The Principle of Normalization in Human Services* (1972); Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents*, at 55 (1974). This legal and professional consensus is reflected in the Federal Medicaid regulations governing under-21 inpatient psychiatric services (45 C.F.R. § 249.10(b)(16)(iii), 41 F.R. 2198 (January 14, 1976)) and institutional care and treatment of the mentally retarded (45 C.F.R. § 249.13(a)(2)(iv), 39 F.R. 2220, 2227 (January 17, 1974)). The President's Commission on Mental Health, in its *Report to the President, supra*, has recommended that "each state review its mental health laws and revise them, if necessary, to assure that they provide for: . . . (b) a right to treatment in the least restrictive setting . . ." (at p. 44).

placement decisions, as the involuntary commitment of adults. In the instant case, the only asserted basis for denying to such children the procedural protections due to adults relates to a somewhat vaguely defined state interest in preserving parental authority and family unity. While, as the District Court noted (*Bartley*, 402 F.Supp. at 1048 n.12, *Institutionalized Juveniles* at A. 1077a), parents are often in the best position to assess a child's needs, their legitimate concerns can be accommodated without vesting in them and state authorities unfettered control over the institutionalization of children. The asserted state interest cannot justify the deprivation of children's personal liberty without due process of law.

A. *The Decisions of This Court Indicate That Parental Authority Is Not Without Limits, and That Children, As Well As Adults, Are Entitled to Constitutional Protections.*

This Court has been presented with numerous cases involving the issue of the scope and nature of parental authority in the upbringing of their children and has generally accorded parents great leeway. *Wisconsin* v. *Yoder*, 406 U.S. 205 (1972); *Ginsberg* v. *New York*, 390 U.S. 629 (1968); *Pierce* v. *Society of Sisters*, 268 U.S. 510, 539 (1925); *Meyer* v. *Nebraska*, 262 U.S. 390 (1923). However, equally as important as the result in *Wisconsin* v. *Yoder*, *supra*, was its carefully circumscribed definition of parents' authority as related to denial of their children's opportunity for a free, public secondary school education. *Id.* at 230-234.[35]

The parental authority recognized by this Court has never been absolute, and where a superseding state interest has been demonstrated, this Court has not hesi-

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[35] Moreover, *Wisconsin* v. *Yoder* turned on First Amendment freedom of religion questions which have no parallel in the instant case.

tated to condone intrusion into the parent-child relationship, primarily in a situation where the child's welfare could be jeopardized:

> But the family itself is not beyond regulation in the public interest. . . . Acting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways. [*Prince* v. *Massachusetts*, 321 U.S. 158, 166 (1944).]

At the same time, this Court has recognized that minors are entitled to many of the same constitutional rights and protections that adults enjoy, *Tinker* v. *Des Moines Independent Community School District*, 393 U.S. 503 (1969), particularly with regard to procedural due process. Minors facing the possibility of institutionalization as a result of delinquent behavior have been accorded almost all the procedural safeguards of adult defendants. *See Breed* v. *Jones*, *supra*; *In re Winship*, *supra*; *In re Gault*, *supra*. Due process protections have been accorded to students facing suspensions from school of ten days or less. *Goss* v. *Lopez*, *supra*.[36] Against this background,

[36] This Court's ruling in *Ingraham* v. *Wright*, 430 U.S. 651 (1977) does not undercut due process requirements in the context of the present case. In *Ingraham* v. *Wright*, this Court held that the infliction of reasonable corporal punishment on public school children by teachers could be accomplished without first resorting to an administrative hearing. This case is distinguishable from the case at hand. First, there is a significant constitutional difference between paddling a child and indefinitely committing him to a mental hospital.

Furthermore, as this Court noted in *Ingraham*:

> Were it not for the common law privilege permitting teachers to inflict reasonable corporal punishment on children in their care, and the availability of the traditional remedies for abuse, the case for requiring advanced procedural safeguards would be strong indeed. [430 U.S. 674.]

No readily apparent authority reveals an analogous common law privilege allowing a parent to commit a child to a state mental

it would be anomalous to hold that procedural due process protections should not apply as well to indefinite commitment of minors to mental institutions.

B. *This Court's Decisions With Regard to Abortion Reflect the Proper Balancing of Interests to Be Applied in the Instant Case.*

In *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976), and *Bellotti* v. *Baird*, 428 U.S. 132 (1976), this Court was confronted with the question, *inter alia*, of whether parents could constitutionally prevent their minor daughters from obtaining abortions under circumstances in which, pursuant to *Roe* v. *Wade*, *supra*, an adult woman would have an absolute right to terminate an unwanted pregnancy.

"Constitutional rights," this Court observed, "do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights." *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 74. Given that in some instances, the state's authority to regulate children may be broader than its authority with respect to adults, the Court continued, it is necessary

> to examine whether there is any significant state interest in conditioning an abortion on the consent of a parent or person *in loco parentis* that is not present in the case of an adult.
>
> One suggested interest is the safeguarding of the family unit and of parental authority. [Citation omitted.] It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor

hospital. *See*, Panneton, "Children, Commitment and Consent: A Constitutional Crisis," 10 Fam. L.Q. 295 (1977). Nor is an analogous remedy for abuse available to the inappropriately committed child.

> patient, to terminate the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the non-consenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of the privacy of the competent minor mature enough to have become pregnant. [*Planned Parenthood of Central Missouri* v. *Danforth, supra,* 428 U.S. at 75.]

The Court's holding in the *Planned Parenthood* case leads directly to the conclusion that the existence of a conflict between parent and child does not mean the constitutional rights of the child must inevitably give way. Certainly, a child's interest in avoiding a wrongful, inappropriate, and potentially lifelong commitment to a mental institution is equivalent in gravity and importance to a minor's right to obtain an abortion, and the same balancing of interests is required. So examined, the child's interest in not being improperly institutionalized outweighs the parent's (or guardian's) interest in having absolute (or near-absolute) control over the commitment decision.

Moreover, if the state, *qua* state, cannot institutionalize an individual without proper procedural protections, such authority cannot constitutionally be delegated to a parent or other third party. *Planned Parenthood of Central Missouri* v. *Danforth, supra,* 428 U.S. at 69.

C. *The District Court Properly Accommodated the Interests of the Parent and Child in Requiring Due Process Safeguards.*

It must be recalled that the District Court in the instant case did not exclude parents or guardians from

participation in the institutionalization decision, but merely interposed a set of procedural protections and an unbiased tribunal (not necessarily a court) as a check on parental (and professional) authority in this area.

> This finding does not mean that when considering whether or not to institutionalize a child, the state should ignore the opinions and observations of the child's parents. Rather the committing authorities should listen carefully to parents who live with and observe the child on a daily basis for they very likely have invaluable information concerning their child. [*Bartley,* 402 F.Supp. at 1048 n.12.]

Such parental participation is clearly contemplated in the *Institutionalized Juveniles* opinion (A. 1081a-82a), and is fully consistent with the balancing approach adopted by this Court in the above-cited abortion cases. Concurring in *Planned Parenthood of Central Missouri* v. *Danforth, supra,* Mr. Justice Stewart and Mr. Justice Powell indicated that the issue might have been different if, instead of a situation where the parent exercised absolute control over the child's decision, the Court were considering a "provision requiring parental consent or consultation in most cases but providing for prompt (i) judicial resolution of any disagreement between the parent and the minor, or (ii) judicial determination that the minor is mature enough to give an informed consent without parental concurrence or that abortion in any event is in the minor's best interest."

Such a provision, said the concurring opinion, "would not impose parental approval as an absolute condition upon the minor's right but would assure in most instances consultation between the parent and child." *Planned Parenthood of Central Missouri* v. *Danforth, supra,* 428 U.S. at 91 (Stewart and Powell, JJ., concurring); *cf. Bellotti* v. *Baird, supra,* 428 U.S. at 147.

This Court's opinions thus contemplate that in situations such as the case at bar, an acceptable formulation can be achieved which allows for parental involvement to an appropriate extent while preserving the rights of the minor child involved, and which utilizes a neutral body to resolve these different and potentially conflicting interests. The order of the court below does no more and, indeed, could do no less.

D. *It Cannot Be Assumed That Parents, Faced With Legitimate Familial Problems, Will Always Act in the Best Interest of Their Children With Regard to Commitment to a Mental Institution.*

As found by the court below, parents (or guardians), even with the best of motives, may not act, or be capable of acting, in the best interest of their children in seeking their institutionalization. *Bartley*, 402 F.Supp. at 1047, *Institutionalized Juveniles*, A. 1077a. This does not mean that such parents are acting malevolently or punitively, although a small number may do so.[37] What it does mean is that very often the child's problem is part of a larger familial problem, and that the entire family should be treated as a whole rather than isolating one member of the family in an institution. But familial problems may produce such a level of frustration and anxiety that parents are simply incapable of objectively considering the child's interests when they make the critical

[37] Evidence that parents do not always act in the best interest of their children is best supplied by the examples of child abuse and neglect. The National Center on Child Abuse and Neglect estimates that if comprehensive reporting existed in all jurisdictions, there would be as many as a million reports of abused and neglected children each year: approximately 200,000 abused and 800,000 neglected. It is estimated that 2,000 children die each year from child abuse and neglect-related injuries. "Child Abuse and Neglect Statistical Information Sheet," p. 4 (available from HEW's National Center for Child Abuse and Neglect).

decision of institutionalization (A. 468, 471, 501, 589-590, 601, 617-618, 628, 998a-1005a).[38]

In other words, minors are likely to suffer or be blamed for problems that plague the entire family and for situations that require help for the family as a unit, not just for the child. *See* 402 F.Supp. at 1044; A. 472, 590, 617-618, 630, 1068a. This being the case, the District Court rightly concluded, parents are in no position to waive a child's personal constitutional rights and make institutionalization decisions virtually on their own. *Bartley*, 402 F.Supp. at 1047-1048, *Institutionalized Juveniles* at A. 1077a.

Other courts have also recognized that a child's best interest is not always the motivating factor behind the institutionalization decision. *See, e.g., Heryford* v. *Parker, supra*; *Saville* v. *Treadway, supra*, 404 F.Supp. at 432; *Horacek* v. *Exon, supra*, Order of June 4, 1974; *New York State Association for Retarded Children and Parisi* v. *Rockefeller, supra*, 357 F.Supp. at 762; *In re Long, supra*; *In re Sippy*, 97 A.2d 455 (D.C. Mun. App. 1953). As the Chief Justice put it several years ago,

> [l]awmakers in recent years have been sensitive to the need to make civil commitment difficult, recognizing the dangers of relatives "farming" out their kindred into mental institutions for motives not always worthy. [*Kent* v. *United States*, 401 F.2d 408, 416 n.4 (D.C. Cir. 1968) (1968) (Burger, J., dissenting).]

[38] An institutional superintendent who has surveyed the literature has concluded that "[o]ne consistent finding is that residential care is not sought solely for the reason of mental retardation. In some negative way, a retarded person presents problems beyond the coping ability of the family." R. Scheerenberger, *Deinstitutionalization and Institutional Reform*, 133 (1976). (The author is the current president of the American Association on Mental Deficiency.) *See* Teitelbaum and Ellis, *supra*, pp. 40-44.

Children, especially those who cannot speak for themselves, must be protected from the risk of such inappropriate and harmful decisions.

E. *Claims of Alleged Traumatizing or Disruptive Effects of Due Process Protections for Children Are Not Supported by the Record.*

Appellants contend that a due process hearing prior to institutionalization will have a traumatizing effect on the child or divide and disrupt the family involved. However, in proceedings below, several experts testified that a hearing may be beneficial for both parent and child. Properly administered, a hearing can impart to the child a sense that he is being dealt with fairly. A hearing may also help to relieve parents' anxiety or guilt by removing from them the necessity of making the final decision (A. 480-481, 483, 494-495, 574-578, 597, 623-624, 1014a-1015a).[39] Even assuming some unpleasantness or familial discord, it is hard to conceive of these effects as more traumatizing than the effects of indefinite commitment, especially if the institutionalization turns out to be inappropriate or unnecessary. Further, there may be cases where there is little or no family harmony left to preserve and a hearing will hardly make matters worse (A. 571-572). See the above quoted passage from *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 75.

Thus the reasons advanced for preserving a system in which the child's interests are not assured of representation cannot be supported on the basis of the record in this case, and, even on their face, do not justify the risk of inappropriate or unnecessary institutionalization.

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[39] It should be remembered, again, that a formal hearing will not necessarily be held in every case as a result of the District Court's decision.

CONCLUSION

For the reasons set forth above, the American Bar Association urges this Court to affirm the judgment and decree of the District Court.

Respectfully submitted,

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APPENDICES

APPENDIX A

ABA Commission on Standards of Judicial Administration

*Standards Relating to Trial Courts.**

2.72 Proceedings Concerning Involuntary Care and Treatment.

In civil proceedings for commitment of the mentally ill, and in all other proceedings in which a disposition of a person may be made on account of his mental or physical condition, the court should ensure that the disposition is made on the basis of adequate information, in accordance with applicable law, and with due regard for the rights of the individual and of the public.

(a) *Procedural Requirements.*

(1) The person who is subject to the proceeding and his family or others immediately concerned for his welfare should be given adequate notice and an opportunity to be heard.

(2) The court should formulate clearly the issues to be resolved, with particular regard for the matters to be considered in the course of medical, psychological, or psychiatric examination and to be made the subject of expert testimony.

(3) Clinical evaluation should be made by professionally qualified persons on the basis of examination and other diagnostic procedures that conform to professionally recognized standards. The person who is the subject of the proceeding should be entitled to obtain and present such an evaluation on his own behalf, at public expense if he lacks the means to obtain it himself. Examiners

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* Based on draft approved at February, 1976, mid-year meeting.

should be required to testify as to the extent of their examination and the grounds for their conclusions. Except on stipulation of both parties, the testimony of all witnesses, including expert witnesses, should be presented in open court, subject to cross-examination, and included in the record of the proceeding.

(4) The person subject to the proceeding should be entitled to the assistance of counsel as provided in Section 2.20.

(5) In exercising its power to order care and treatment, the court should consider possible alternative dispositions, imposing only as much restraint as is necessary for protection of the individual, his family, or the public, or for accomplishment of required treatment.

(6) When commitment is ordered, the court should specify its purposes, the terms and conditions of any custody or restraint that may be directed, and a time limit, upon the expiration of which the matter is to be brought before the court for further consideration unless the person has been discharged prior to that time according to law.

(7) Whenever a person is found to be mentally ill or mentally retarded or is committed to an institution where he may be unable to take an active part in management of his property or business interests, and it appears that the commitment may be of long duration, the court should inquire into the nature of such interests and the possibility that guardianship of his property or like safeguards should be established to protect them.

(8) Observational commitments. Involuntary commitments for the purposes of observing the individual's mental or physical condition should be to the least restrictive environment in which the observation can be conducted and only for that period of time which is reasonably necessary to complete such observation.

(9) Emergency commitments. Emergency commitments without judicial proceedings should be permitted only in cases of extreme physical danger to human life, health, or safety, and should not be continued beyond the time reasonably necessary to arrange for a preliminary hearing before a judge.

(b) *Staff Assistance.* The court should have sufficient supporting staff and access to psychiatrists and other professionally qualified experts to carry out its responsibilities under this Section.

COMMETARY

In recent years the traditional procedures for civil commitment of the mentally impaired, and procedures involving defendants in criminal cases who plead insanity or whose competence to stand trial is in question, have been augmented by an array of statutory procedures for commitment of narcotics addicts, alcoholics, and persons mainfesting such types of statutorily defined social deviance as "sexual psychopathy" and "defective delinquency." Because these proceedings are generally termed civil rather than criminal, even when they arise out of criminal prosecution, fewer procedural protections are generally afforded the persons subject to them. The distinction between civil and criminal in many of these cases, however, is more apparent than real. Commitment to an institution on the ground of mental or physical condition is a deprivation of liberty and has many of the characteristics of penal sanctions: confinement (often under harsh conditions), isolation from family and friends, inability to earn a living, persisting social stigma, and sometimes loss of civil and professional rights. Like criminal prosecution, it is often the result of an alleged offense against the law or mores of the community. Procedural safeguards in these cases should not depend on mechanical application of a dichotomy between civil and criminal procedures.

The role of the court in commitment and related procedures should be clearly understood as including responsibility for determining the legal and factual issues that may be presented. The court should not simply ratify recommendations of medical examiners on the assumption that the question is one of medical diagnosis. Statutory definitions of the classes of persons subject to these proceedings do not necessarily correspond to any generally accepted medical diagnostic category. Moreover, psychiatric diagnosis by one diagnostician may differ greatly from that by another who is equally well qualified, and may sometimes be influenced by irrelevant or insubstantial therapeutic, social, or institutional considerations. The lack of precise criteria for determining the potential dangerousness of an individual should be taken into account, as should the tendency of medical witnesses to overpredict dangerous behavior. The medical expert must provide the court with the medical facts and medical opinions essential to a decision, including diagnosis, prognosis, suitability of proposed treatment, prospect of improvement under possible alternative dispositions, and the like. However, the ultimate decision is not essentially a medical one and involves a substantial element of legal discretion. The special problems encountered in these cases make it desirable that judges have been prepared by experience or training for their role. [Reference omitted.]

Notice and an opportunity to be heard should be provided even though the person subject to the proceeding appears to be mentally incapable of acting upon them. Notice may be delivered by a social worker or other trained person acting on behalf of the court who can explain its meaning and offer assistance in obtaining counsel and making preparations for the hearing. Notice of the hearing should also be given to relatives or friends who may assist the respondent or act in his behalf.

Notice should be given sufficiently in advance of scheduled court proceedings to afford a reasonable opportunity for preparation, and should inform the person with particularity of the basis for his detention, his right to counsel and to trial by jury (where available) and the standard upon which he may be detained.

The person who is subject to commitment should be personally present, except where the court finds that he is incapable of attending the hearing or that attending the hearing would worsen his condition or might incite him to injure someone else as a result of hearing the testimony. He should in any event be represented by counsel. See Section 2.20.

Where the respondent is in such a condition that he cannot be present at the hearing, a conference with the judge may allow him to state his case without being required to be present at the formal hearing, but such a conference should not take the place of an evidentiary hearing. Disposition should be made only upon a hearing at which medical and other witnesses are present and subject to cross-examination by counsel and questioning by the court unless the parties agree to presentation on the basis of written documents. Hearings should be on a formal record and decisions based on written findings of facts.

Hearings under sex-psychopath and similar quasi-criminal statutes should provide all the procedural safeguards of a criminal trial. In cases where determination of mental condition is related to criminal proceedings, a separate hearing should be held on mental condition, with adequate notice to the defendant of the questions at issue and the possible consequences of the determination.

The usefulness of medical reports and testimony can often he greatly improved if the court advises examiners

and witnesses in advance of the kinds of information it requires for an informed decision. This can be done through examination forms stating the legal questions before the court (for example, whether the individual is competent to stand trial), and indicating the facts required for a finding on the question at issue (for example, whether he could cooperate with counsel in his own defense). Examiners should be required to state the nature and extent of their examination and the grounds on which they base their findings and conclusions.

Counsel for the respondent should be afforded sufficient time and resources to consult with his client, secure independent professional examination if desired, and inform himself about possible alternatives to commitment. Special training for counsel in mental illness cases can be helpful in improving the quality of representation.

In reaching a disposition, courts should consider all reasonable alternatives such as voluntary hospitalization and treatment in the community without full-time hospitalization. Dispositions should provide for the minimum amount of restraint consistent with accomplishing the purposes of the law.

Commitments should be limited to a relatively short period, at the end of which the necessity of further commitment should be judicially determined. Periodic review of the status of committed persons should be initiated by the court unless a public guardian or defender agency can assume responsibility for doing so. The review should involve notice and formal hearing, with the respondent represented by counsel and medical witnesses subject to cross-examination as in the original commitment proceeding. All reasonable alternatives to commitment should again be considered, and a realistic assessment made of the likelihood of accomplishing further therapeutic objectives by commitment.

APPENDIX B

ABA House of Delegates—Policies Adopted August, 1978

COMMENDATION OF REPORT OF PRESIDENT'S COMMISSION ON MENTAL HEALTH

BE IT RESOLVED that the American Bar Association commends the Report of the President's Commission on Mental Health as an important and valuable study for consideration by officials and citizens concerned with improvement of the nation's mental health system; and

BE IT FURTHER RESOLVED that the American Bar Association endorses those recommendations of the President's Commission on Mental Health providing for protection of the human and legal rights of mentally disabled, i.e., the recommendations within the Report's section on "Protecting Basic Rights" which recommend that:

[1] All Federal agencies enforce existing laws and regulations which prohibit discrimination against mentally disabled persons and seek to equalize opportunities for such individuals.

[2] All Federal agencies review their statutes, regulations, and programs for instances of discrimination against mentally handicapped persons.

[3] The Department of Health, Education and Welfare vigorously implement the requirements of the Education for All Handicapped Children Act and formulate regulations to assist school districts to provide for the mental health needs of children and youth.

[4] Each state review its mental health laws and revise them, if necessary to ensure that they provide for:

a) a right to treatment/right to habilitation and to protection from harm for involuntarily confined mental patients and developmentally disabled individuals;

b) a right to treatment in the least restrictive setting;

c) a right to refuse treatment, with careful attention to the circumstances and procedures under which the right may be qualified; and

d) a right to due process when community placement is being considered.

[5] Each state have a "Bill of Rights" for all mentally disabled persons, wherever they reside.

[6] Mentally disabled persons in detention or correctional institutions should have access to appropriate mental health services on a voluntary basis and such access should not be connected with release considerations.

[7] All recipients of Federal funds to provide mental health services be required to adhere to certain basic principles of confidentiality, and that other institutions and facilities be encouraged to follow this practice.

[8] The establishment of advocacy systems for the representation of mentally disabled individuals. In adversary or judicial settings we recognize the importance of counsel to represent not only the mentally disabled client (or those acting in his or her behalf) but also the state or provider against which a claim is made.

[9] Each State review its civil commitment and guardianship laws and revise them, if necessary, to incorporate increased procedural protections.

STATE ADVOCACY PROGRAMS FOR THE MENTALLY DISABLED

RECOMMENDATION

BE IT RESOLVED that the American Bar Association urges the establishment of advocacy programs for the representation of the mentally disabled in all states, and calls on the Legal Services Corporation to increase its activities so as to ensure more adequate and effective legal services for the mentally disabled poor in institutions and in the community.